DOCUMENT RESUME

ED 432 358 PS 027 141

TITLE	Access to Comprehensive School-Based Health Services for Children and Youth, 1995-1998.
INSTITUTION	George Washington Univ., Washington, DC. School of Public Health and Health Services.
PUB DATE	1998-00-00
NOTE	58p.; Published three times a year.
AVAILABLE FROM	"Making the Grade," George Washington University, School of Public Health and Health Services, 1350 Connecticut Avenue, NW #505, Washington, DC 20036; Tel: 202-466-3396; Fax: 202-466-3467; Web site: http://www.gwu.edu/~mtg: e-mail: mtg@gwu.edu
PUB TYPE	Collected Works - Serials (022)
JOURNAL CIT	Access; Sum 1995-Fall 1998
EDRS PRICE	MF01/PC03 Plus Postage.
DESCRIPTORS	Accreditation (Institutions); *Adolescents; *Child Health; *Children; *Comprehensive School Health Education; Models; Newsletters; Public Relations; *School Health Services
IDENTIFIERS	*School Based Health Clinics; School Based Services

ABSTRACT

This document consists of 11 consecutive issues of the newsletter "Access," published across a four-year period. "Access" presents information on public policy and research of interest to school-based health programs (SBHC) for children and youth. The major topics covered by the newsletters are as follows: (1) a conference, "Breaking New Ground," in Washington, DC to establish a national movement to support improved health services for children through school-based health care (Summer 1995); (2) states broker relationships between school-based centers and managed care plans (Fall 1995); (3) promoting team work among health center staff, national centers funded to support school mental health programs (Winter/Spring 1996); (4) Louisiana's school-based health centers, report on the conferences of the National Assembly on School-Based Health Care (Summer 1996); (5) growth of school-based health centers, hospital sponsored SBHCs, the Making the Grade Web Site (Fall 1996); (6) evaluation of SBHCs, teens' use of SBHCs and health maintenance organizations, and partnerships to care for uninsured children (Spring 1997); (7) community planning for SBHCs, public relations for SBHCs (Summer 1997); (8) insurance expansions and SBHCs, funding comprehensive SBHCs, dental care in SBHC (Fall 1997); (9) exploring the evoluation of school-based health centers (Winter 1998); (10) local funding for SBHCs, the Balanced Budget Act and managed care (Spring 1998); and (11) accreditation of SBHCs, results of the Making the Grade User Survey (Fall 1998). (KB)

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Access to Comprehensive School-Based Health Services for Children and Youth. 1995-1998

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SUMMER 1995

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

School-Based Health Care Assembly Breaks New Ground

More than 500 people from around the country gathered June 23-25 to establish a national movement to support improved health services for children through school-based health care. The conference — appropriately titled *Breaking New Ground!* — brought together school-based health care providers, researchers, and advocates for three days of activities in Washington, DC.

"This is clearly a historic occasion," said Joy Dryfoos, a long-time leader of school-based health care. "For the first time, the entire school-based health care movement is building a strong organization with the capacity for advocacy, networking, and sharing resources."

If the crowd's size and enthusiasm were any indication, the effort promises to be a major success. Conference organizers expected a turnout of 350 people, but they significantly underestimated the desire for this meeting. More than 500 attendees from 42 states and the District of Columbia flocked to Washington for the occasion. Half of the participants were people who work on the front lines of school-based health care — 250 health center staff and community organizers. The other half reflected interest from all quarters, including educators; health care institutions; private funders; community organizations; and local, state, and federal governments.

"It's wonderful to see all this energy collected in one place," said Christel Brellochs, director of the School Health Policy Initiative, which is based at Montefiore Medical Center in New York. "This conference is a catalyst that's going to propel a broad range of players with a lot of common aims to a new level of collaboration."

"Now the work begins!" Newly-elected officers, President Donna Zimmerman, Health Start, Inc., St. Paul, Minnesota (right), with At-Large Member Linda Juszczak, Northshore University Hospital, New York, and Treasurer John Santelli, M.D., Centers for Disease Control, Atlanta

The Fruit of Long Labor

In part, *Breaking New Ground!* was a well-earned celebration of more than two decades of achievement. During the past 25 years, the number of school-based health centers in the U.S. has

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Breaks New Ground

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grown dramatically — from two centers in 1970, to 20 in 1980, to an estimated 650 today. In recent years many states have begun to fuel this growth with government funding. Between 1992 and 1994, state funding for school-based health centers increased by 145 percent.

Numbers like these are important milestones in the development of school-based health care, and *Breaking New Ground!* served as a clear marker that the movement has reached a critical mass.

"Little did we realize when we started on this journey that we'd reach this point," said Mary Baca, a Denver community health activist who has been instrumental in nurturing Colorado's school-based health centers.

Julia Graham Lear, director of *Making the Grade's* National Program Office, credited much of school-based health care's success to the care and persistence of community members like Baca. "The growth of school-based health centers is attributable to the willingness of those involved to see things as possible that most can't even imagine," Lear said. "These people have demonstrated the capacity to dream, but also the fortitude to make those dreams a reality."

Filling a Critical Gap

It was necessity, however — not celebration — that was the primary force behind the historic conference. While a number of organizations and institutions have taken leading roles in advancing school-based health care over the years, no unifying umbrella group has emerged. The recent proliferation of school-based health centers intensified the need for a formally coordinated support system. That need became especially evident in 1994, during the national health care reform debates. As various reform proposals were debated, school-based health care advocates had no unified voice. Consequently, they had to rely on other organizations with different agendas to take them under their wings.

In June 1994, the School Health Policy Initiative and Advocates for Youth, located in Washington, DC, organized a meeting of school-based health care providers, researchers, and advocates to explore possibilities for uniting the many agencies, organizations, and individuals working in the field. That meeting prompted a series of meetings that led to *Breaking New Ground!* "It took an amazing amount of multidisciplinary cooperation to pull this conference together," said Kate Fothergill, program director of The Support Center for School-based and School-linked Health Care at Advocates for Youth. "The challenge will be to continue that cooperation to provide technical assistance at the local level *and* advocacy at the national level."

These topics were prominent among the rich variety of sessions offered at the conference. Program management, comprehensive health service delivery, financing, coalition building, and advocacy were all covered extensively. Again and again, discussions turned to two themes — managed care and violence — that are currently permeating many aspects of school-based health care. (See "School-Based Health Care Advocates Speak Out Against Violence" on page 4).

Embarking Under a Banner of Unity

After two days of intensive workshops and networking, the conference culminated in the birth of a new organization, the National Assembly on School-Based Health Care. The Assembly's mission: to promote access to quality primary care for young people, while serving as a collegial home for the growing number of interdisciplinary professionals affiliated with school-based health centers.

The Assembly's fundamental goals include: expanding the number of school-based health centers; promoting quality and consistency of school-based health center services; and developing long-term strategies to institutionalize school-based health care. Conference participants commented that in order to achieve these goals, supporters of school-based health care must carry forward the unity and energy that characterized the conference.

"I want us to come out full-force as a team," said Sheila Sholes-Ross, coordinator of the Coalition for Healthy North Carolina Youth. "We have to transcend partisan politics and say, 'This is how we're going to change society: We're going to give *all* our children the opportunity to learn.'"

Donna Zimmerman, executive director of St. Paul's Health Start, Inc., which manages seven school-based health centers, was elected president of the National Assembly on School-Based Health Care. She made it clear that building on the success of *Breaking New Ground!* will be a priority during

Sylvia Sterne, Director of Louisiana's Adolescent and School Health Division, and Lynn Noyes, Director of Connecticut's School and Adolescent Health Unit, discuss Medicaid managed care at a roundtable meeting of state agency representatives.

her tenure. "I am struck by the number of people here, particularly from the local programs," Zimmerman said. "One thing I want the Assembly to do is continue having member-driven meetings each year."

If a bottom-line message emerged from the conference, it was that school-based health care's success has — and always will — depend upon the energy of countless committed individuals. The National Assembly on School-Based Health Care creates a powerful new vehicle to organize, channel, and multiply that energy.

"You don't have to be part of our past to be part of our future," said *Making the Grade's* Lear. "What you can take from our past is a great deal of hope for our future."

George Shaler, West Virginia School-Based Health Center Initiative, leads the West Virginia contingent in a discussion of state school-based health care issues.

National school-based health care leaders (from left) Debra Hauser McKinney, Advocates for Youth; David Kaplan, Denver Children's Hospital; Joy Dryfoos, Independent Researcher; and Jane Martin, HHS Bureau of Primary Health Care, are all smiles after the adoption of the new national membership organization.

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School-Based Health Care Advocates Speak Out Against Violence

"If we don't handle the issue of violence, I can't see how we'll tackle any issues we care about in children's lives," said Geoffrey Canada in a stirring and energizing keynote address to the *Breaking New Ground!* conference. "There's no way that you can be for children and not take this issue on."

Canada, president of the Rheedlen Centers for Children and Families, recently published his first book, *Fist, Stick, Knife, Gun,* to widespread critical praise. He has won several prestigious awards for his work with children.

"I've been in this field for 20 years, and I quite honestly have never seen anything like what we face today," he said. "The dangers facing our children are greater than ever, and the issues children bring into schools are much more complicated."

Canada's speech was just one of many violence-related discussions that took place during the conference. And his characterization of today's situation — ominous and urgent — was echoed again and again.

A Growing Circle of Victims

Those who work closely with children, particularly in communities racked by violence, know its devastating impact on young lives. Hope Hill, director of the Howard University Violence Prevention Project, works with elementary students who can rent handguns on the street for a few dollars an hour. Hill, in presenting her study to Assembly participants, reported that violence can impair ability to develop relationships, compromise child development, and curtail children's vision of the future, among other things.

In sum, she said, "Violence destroys childhood."

In Canada's view, violence has changed the very nature of what it means to be a child in this country. "When I grew up, there were rules to violence. You could at least predict that you would get to school and home again," he said. "But today we have a group of young people who never learned to de-escalate. Everything is a major infraction. Their disagreements are lethal."

Statistics bear this view out. Conference presenter Don Schwartz, an injury prevention expert at the Children's Hospital of Philadelphia, said that while young people are the leading victims of violent crime in the U.S., the only measure of violence against youth that has rapidly worsened in recent years is homicide. He pointed out that in 1986, for the first time in American history, homicide rates among young people surpassed those among adults. And in 1991, for the first time, homicide became the number two killer of American adolescents.

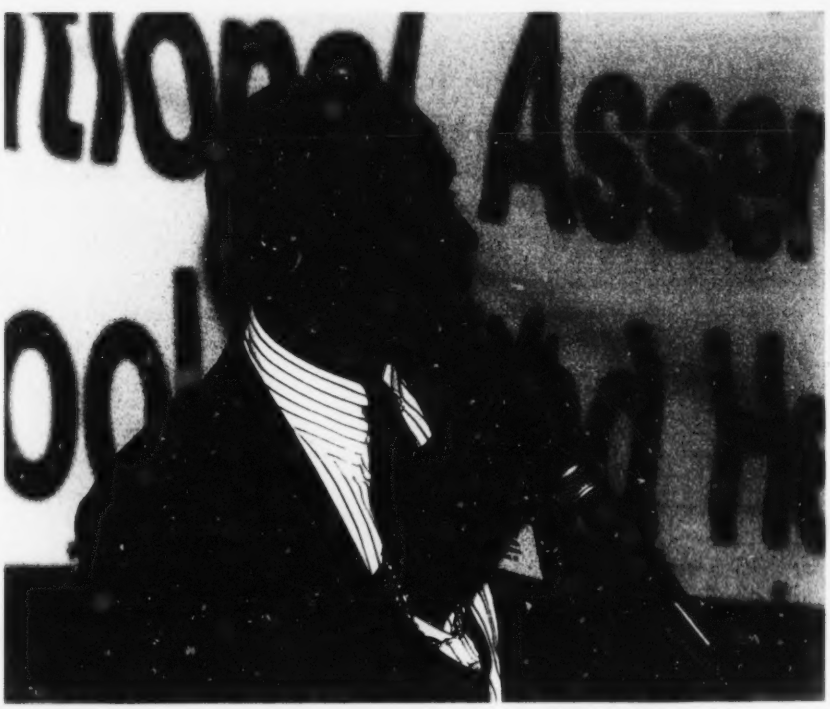
Outposts in a War Zone

Today, growing up in this country's violent communities is like growing up in a perpetual state of war. "Our schools are battlegrounds," said Canada, adding that many children develop the classic symptoms of post-traumatic stress syndrome — more commonly associated with soldiers home from war. "The difference for these kids is there's no 'post,'" he said. "The war is home, and there is no place to go."

Mark Weist, who works in child and adolescent psychiatry at the University of Maryland School of Medicine, said that simply witnessing violence often leads to post-traumatic stress syndrome in young people. "The most important thing is to provide a nurturing and safe environment to help the child recover," Weist said, "But that's often impossible. The pervasiveness of the violence is astounding."

Amidst such danger, school-based health centers become particularly critical, according to Weist in his workshop presentation. "Providing mental health services in schools is one of the most important things we can do to address this problem," he said. "Over 83 percent of the kids we see who have significant problems have no prior mental health service involvement. We're reaching kids who haven't been reached."

Canada put it this way: "Whether health clinics should be in schools is a stupid debate. We know where children are — in school. We ought to have the services in there."



Keynote Speaker Geoffrey Canada rouses the standing room only crowd.

Prevention and Political Action

Clearly, school-based health centers can play a leading role in many of Schwartz's violence prevention recommendations: identifying at-risk families and youth, counseling children about violence and weapons, discouraging substance use, and identifying school failure. For further recommendations, Schwartz referred participants at his conference workshop to two publications: *What Works in Reducing Adolescent Violence: An Empirical Review of the Field*, by Patrick Tolan and Nancy Guerra (Center for the Study and Prevention of Violence, Institute for Behavioral Studies, University of Colorado at Boulder, Box 442, Boulder, CO 80309-0442) and *Youth Violence: A Reason to Hope*, which is available from the American Psychological Association.

While Canada's prescription similarly emphasized direct, hands-on intervention, he also stressed advocacy. "It's clear that this is war — we're in a fight for resources," he said. "Yet the resources are being drained. The silent majority in this country has to speak up."

And if we don't win the battle for resources? The war of street violence will surely spread.

"Some people think this war isn't coming to their neighborhoods," Canada said, "but I've got news for you, this war is on the march. Just give it a little time, this issue is going to be paying you a visit real close to home."

"Providing mental health services in schools is one of the most important things we can do to address this problem. Over 83 percent of the kids we see who have significant problems have no prior mental health service involvement. We're reaching kids who haven't been reached."

Mark Weist

Managed Care Program Offers $2 Million in Violence Prevention Grants

Mercy Health Plan, the largest Medicaid managed care program in Pennsylvania, has committed $2 million toward a violence prevention program over five years. The program initially will target Southwest Philadelphia, supporting multidimensional community initiatives to intervene in risk factors that could lead to youth violence.

A request for proposals will be made available to interested community agencies located in or partnering with organizations located in Southwest Philadelphia. Proposals will be reviewed by a Mercy Health Plan committee, and grant recipients will be announced this fall. For more information, call Mercy Health Plan at (215) 496-6360.

Making a Case for Case Management

By Jap-Ji Kaur Keating

As increasing numbers of students come to school with an array of problems that deeply affect their academic performance, schools must begin to see themselves as full-service institutions. This view inspired Dr. Albert Smith, director of the University of Washington's Center for the Study and Teaching of At-Risk Students (C-STARS), to create guidelines for an interprofessional case management approach for the delivery of school-based human services.

The C-STARS case management guidelines cover all the bases: assessment, development of service plans, brokering, service implementation and coordination, advocacy, monitoring and evaluation, and mentoring. Taking a longitudinal approach, the model relies on partnerships among social service professionals, educators, and health workers to coordinate services for students and families.

C-STARS is currently in place as part of a national dropout prevention project involving 24 schools (K-12) in five districts in the state of Washington. In each school, a multidisciplinary team meets regularly to discuss the needs, strengths, and resources of students referred for case management and to plan services for these students and their families. Teams include teachers, school psychologists, special education staff, substance abuse and behavioral intervention specialists, and representatives of community agencies and child welfare agencies.

Schools Already Seeing Progress

Millwood Early Childhood Center in Spokane has used this model for two years. All faculty and staff participate in the interprofessional team on a rotating basis. Parents of the children served are also active team participants.

The team approach has enabled Millwood to meet the needs of a large group of students. An additional benefit: Families are better able to advocate for themselves in the community because of the support they receive at school.

At Purdy Elementary School in Gig Harbor, the team advocates for students with teachers and service providers and has developed a partnership with an outside agency to provide counseling to students. After meeting with a child's parents and classroom teacher to assess resources and needs, Purdy's team

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A Case for Case Management

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plans appropriate services. So far, the counselor at Purdy has noted improved attendance and self-esteem in the students being served. Parents also have an improved view of the school as a result of the team's efforts on behalf of their children.

Capitalizing on Computerization

Working with the Washington State Migrant Council, C-STARS has developed a unique tool to enhance the case management model's performance: a computer software program that allows users to efficiently manage the cases of students at risk of dropping out of school. Known as the Computer Assisted Risk Accountability System (CARAS), this software helps prioritize a student's risk factors.

According to Eduardo Armijo, C-STARS evaluation coordinator, CARAS is able to assist case management teams in several ways. The software helps the team develop an individualized service plan, document family demographics, monitor and evaluate student and family progress, and provide a user-friendly method of reporting up-to-date information on case loads. This last function is especially helpful in team meetings, when members need a quick, concise update on targeted students.

Data collected through CARAS assist schools in all phases of a service plan, from referral to closure. The information also enables case managers to see the scope of problems and the impact of interventions over a period of time. Moreover, Mr. Armijo says CARAS greatly assists in both formative and summative evaluation by allowing for careful documentation of case management activities.

The bottom line: All of these features benefit students and families by keeping case histories in a confidential, well-organized, detailed system that enhances school-based service delivery.

Disseminating the Model

Dr. Smith and his colleagues at the University of Washington are busy expanding the work of C-STARS. For example, the model is being adapted site-specifically by many school- based programs in Alaska that previously struggled to provide efficient, cost-effective help for students.

Eventually, Dr. Smith hopes to help school communities throughout the nation coordinate health, social and education services that will enable students who might otherwise drop out of school to become successful, productive adults.

About the Author: Jap-Ji Kaur Keating is a doctoral student in Educational Leadership and Policy at the University of Washington, with a focus on the disenfranchised.

Involving Parents in School-Based Health Center Planning

Getting parents involved in helping to plan services for families can be an ongoing challenge for many school-based health centers. Oregon's Making the Grade program office developed the following guidelines that may help you increase parent participation.

- **Reach beyond the traditional groups when seeking parent input.** Health centers tend to overuse the highly motivated parents who participate in PTAs, PTOs and school booster clubs. This is like choosing only honors students to lead peer counseling programs. Because the parents who participate in these organizations are likely to be already more involved than most parents in their children's schooling, they represent a skewed sample, not the norm.
- **Seek out parents whose children have had difficulties in school.** Parents whose children have been in trouble will have useful perspective on the needs of families with serious problems.
- **Help parents with child care.** Parent involvement in school-based programming is often limited by child care limitations. The simplest solutions: Provide care or pay for it.
- **Plan activities around parents' schedules.** Consider meeting times in light of parent convenience, and be aware of potential conflicts in the community calendar.
- **Consider paying parents honoraria.** Professionals on multidisciplinary teams are usually compensated by their agencies. Isn't it fair to compensate parents for the wages they lose for taking time out of their work week to participate in health center programs?
- **Expect mistrust.** Many of the parents you most want to be involved have had only negative or adversarial contacts with schools or other public agencies in the past. Be patient, and work to build trust and positive communications.
- **Listen.** Actively seek genuine input from parents — and respond to it. If you only invite parents to rubber stamp your own ideas, then you are not acknowledging the real value that parents can contribute. Involve parents as real contributors from the beginning, and give them real responsibilities.

The Program

Through *Making the Grade*, the Robert Wood Johnson Foundation funds states to work with communities to plan the delivery of comprehensive school-based health services for children in grades K-12.

At the state level, agencies will develop policies that support providing comprehensive primary health care services in schools and that reduce barriers to organizing, financing, and staffing school-based health centers. At the community level, schools, health providers, and representatives of community groups and parents will work together to develop plans for putting in place the comprehensive centers at two or more schools.

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ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

States Broker Relationships Between School-Based Centers and Managed Care Plans

Although managed care organizations and school-based health centers have been part of the health care delivery market for more than 20 years, in many states, the two have never met. In some states, they have been introduced only recently. For the most part, these new relationships are being developed at the community level where individual health centers or their institutional sponsors are attempting to negotiate with local managed care plans. But in a few states, health planners and policy makers are recognizing the need to integrate the two as part of their statewide efforts to expand support for school-based health centers and increase access to care for school-age children.

In the last decade, the number of school-based health centers across the nation has increased exponentially from 40 in 1985 to 650 in 1995—due to expanded federal and state funding support. However, significant reductions in that support are now probable as the U.S. Congress moves to balance the federal budget through cost-cutting measures, which will place more fiscal pressure on the states and force community-based health providers to compete for fewer public health dollars.

Inside this Issue

- HMOs & SBHCs in Baltimore
- Philadelphia Guidelines for SBHCs

Although 29 states report having established Medicaid reimbursement procedures for services provided in school-based health centers, patient revenues, historically, have contributed relatively little to school-based health center finances. In some cases, however, school-based health centers that have established fee-for-service billing arrangements with their state's Medicaid programs are beginning to see their limited Medicaid revenues decline as more and more states move their publicly insured beneficiaries into managed care plans. For example, school-based health centers in the Bronx estimated a $30,000 revenue loss last year for services they provided to students enrolled in Medicaid managed care programs. And, two school-based health centers in Memphis saw their Medicaid revenues decline from $16,000 to $2,500 in the first six months of TennCare, Tennessee's Medicaid managed care program.

"Since many state governments are attempting to increase access to health care for children through school-based health centers as well as improve the organization and financing of health care for low-income residents through Medicaid managed care, it seems logical that states would encourage relationships between the two entities," said Julia Graham Lear, director of the *Making the Grade* program.

This is, in fact, what some states, including Massachusetts and Colorado, are doing—although, they are approaching the challenge very differently.

Tale of Two States

In Massachusetts, the implementation of mandated Medicaid managed care more than two years ago raised concerns

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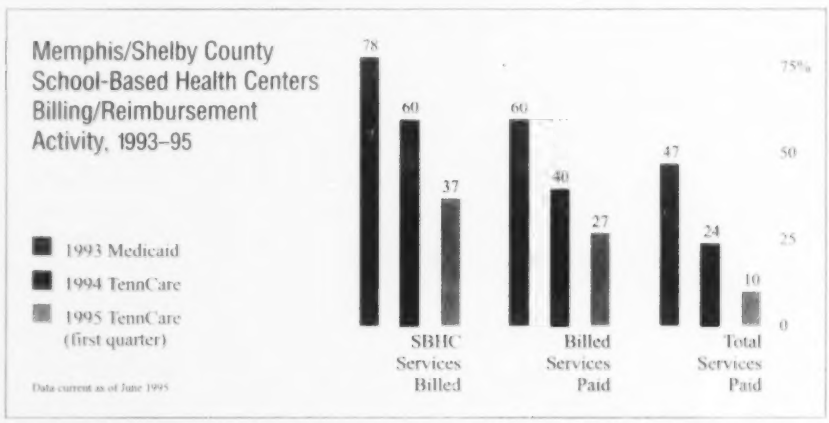

Billing and reimbursement data from two school-based health centers in Memphis show a decline in Medicaid reimbursements under TennCare, Tennessee's mandated Medicaid managed care program. The centers saw their Medicaid revenues drop from $16,000 to $2,500 in the first six months of TennCare.

States Broker Relationships

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about the potential for negative impact on school-based health centers. Since that time, the state's Division of Medical Assistance (its Medicaid bureau) and Department of Public Health have been working to create partnerships between school-based health centers and the 12 Medicaid health maintenance organizations (HMOs) in the state. To facilitate this goal, the state is requiring Medicaid HMOs to contract with school-based health centers to deliver care to school-age children.

"When the state Medical Assistance Office mandated linkages between school-based health centers and managed care organizations as part of its contracting policies with managed care organizations, it meant there would be an open road ahead of us—not an easy one, but an open one."

Karen Hacker

"Initially, the school-based health centers wanted us to make them 'carve-out' providers," said Louise Bannister of the Massachusetts Division of Medical Assistance. "But we feel that because so many of the services they provide are primary care services, it is important for the school-based health centers to be part of the managed care system. And, since we are forcing them to work within that system, we feel it is our duty to help them integrate into it."

In addition, the state agencies are pursuing a number of other strategies to promote relationships between managed care plans and school-based health centers. For example, the state has developed quality standards for school-based health centers to reassure managed care plans about the care that is delivered in these settings. The state also educates managed care providers about school-based health centers through monthly roundtable meetings with HMO representatives and a statewide outreach system that targets more than 1,300 primary care clinicians.

"Without state pressure for change, we would not be doing anything," said Karen Hacker, MD, director of the department of adolescent and school health for the Boston Department of Health and Hospitals, which sponsors eight of Boston's 13 school-based health centers. "When the state Medical Assistance Office mandated linkages between school-based health centers and managed care organizations as part of its contracting policies with managed care organizations, it meant there would be an open road ahead of us—not an easy one, but an open one."

Different Approach, Same Goal

Although Colorado is equally interested in creating an open road for its 26 school-based health centers and numerous managed care organizations, it is mapping a different route toward the same destination.

"Mandates are not very acceptable in Colorado, even when they might be to everyone's best advantage," said Bruce Guernsey, director of the Colorado School-Based Health Care Initiative, a public-private task force created to explore long-term financing strategies for school-based health centers. "Private, market-based solutions are definitely what people favor."

Colorado's interest in expanding long-term financial support for school-based health care services goes beyond the development of relationships between school-based health centers and managed care organizations. Because managed care currently represents only 11 percent of the Medicaid market and approximately 25 percent of the private insurance market, the state is also targeting traditional indemnity insurance carriers in its efforts to integrate school-based health centers into the health care delivery market.

"The problem in Colorado is that school-based health centers have not been integrated into the private health insurance system," said Guernsey. "Most of the centers have not done third-party billing and have had a limited relationship with Medicaid. So, the state health department decided to establish a relationship with Medicaid through managed care and other insurance carriers and develop policy initiatives that increase access to health insurance for kids. And, along those lines, they're trying to find ways to promote school-based health care as a cost-effective delivery system."

Toward this end, the state task force has produced a number of support documents with input from insurance companies and school-based health centers. These documents include a school-based health center benefits package, a market share analysis, and draft accountability measures. Also, a cost analysis—based on data from Denver school-based health centers—was performed to inform third-party payers about operating expenses and costs per enrolled student.

"When fostering contractual relationships between school-based health centers and insurance carriers, the best thing the state can do is demonstrate that the centers can help managed care organizations meet quality and access standards," said Annie Van Dusen, senior policy analyst with the Colorado Department of Health Care Policy and Financing. "This year, we plan to develop a model contract for school-based health centers. And, at the same time, we will draft a model protocol for coordinating services between school-based health centers and children's primary care providers."

The idea that school-based health centers and managed care plans should combine their efforts to deliver high-quality, cost-effective health care services to children and adolescents is still relatively new. But, the idea is clearly supported by the fact that Massachusetts and Colorado—states with very different philosophies regarding the role of government—each determined that they should, in their own ways, facilitate relationships between these two different entities.

"If we assume that state governments are reasonable and responsible," said Lear, "then we have to assume that they will be looking at ways in which Medicaid managed care and school-based health centers, with their natural tensions, can be reconciled."

HMOs and School-Based Care: A Match Made in Baltimore

Bernice Rosenthal, MPH, and Edward Hinman, MD, FACP, pioneers in a unique partnership between school-based health centers and managed care, described their work in nuptial terms. "It's like a marriage," said Rosenthal, administrator of comprehensive school health services for the Baltimore City Health Department. "We fight over children and finances."

Their "marriage" may turn out to be one we can all celebrate—a new model for the financing and delivery of school-based health care.

Getting to Know Each Other

Hinman is medical director of Total Health Care (THC), a staff-model HMO that is also a federally qualified community health center. A not-for-profit with a budget of $60 million, THC is committed to providing care for underserved and at-risk populations.

One way THC does this is by delivering preventive health care through school-based health centers. Since 1992, THC has authorized the health department's school-based health centers to provide specific services to students enrolled in the HMO. THC reimburses the health centers for these services at Medicaid rates. The school-based health centers try to arrange for THC to deliver services, but if the HMO cannot see a student in a timely manner, or if the student has never visited THC, the health centers are authorized to provide the needed treatment.

At first, THC staff viewed these school-based health center visits as out-of-plan utilization that threatened continuity of care. School-based health center staff were similarly disinclined to recognize THC as the students' medical home. While there has been progress, these problems have not been eliminated.

So, THC and the school-based health centers are helping their staffs learn to view each other as partners. For example, the health centers have held joint meetings with THC physicians and nurse practitioners.

"Overall, we've made great strides," Rosenthal said. "We have a vehicle to work out problems, and we're talking like partners. We have to continue. If we don't have a dialogue, we're nowhere."

Taking the Plunge

Recently, THC upped its investment in the dialogue. In January 1995, the HMO took responsibility for launching and operating three elementary school-based health centers. In a cooperative staffing arrangement, the health department, THC, and the University of Maryland School of Nursing supply each of these centers with a full-time nurse practitioner, a part-time school nurse, and a certified medical assistant. Students who are enrolled in THC and have parental consent receive full services on site. Students who are not enrolled but have parental consent either receive on-site care or are sent elsewhere, as directed by their medical home. Unenrolled students without parental consent receive good Samaritan triage.

Hinman hopes this arrangement is the beginning of a broader operation. THC is already negotiating with one school to remodel a designated space into a comprehensive health center. Once this facility is operational, the HMO plans to open it to all local children up to age 18, regardless of their school enrollment status. Ultimately, THC intends to make the center available to all residents in the community.

This experiment will test THC's belief that it can manage school-based clinics in a manner that will generate enough revenue to offset expenses. "Our hypothesis is that if we use the school-based health centers as an integral part of THC's staff model approach, and if we get a high enough penetration of enrollment at the school-based health centers, we can operate at a break-even point," Hinman said.

The THC board has given Hinman three years to prove his hypothesis.

Happily Ever After?

While Rosenthal is all for HMOs getting more involved in school-based health care, she doubts Hinman's hypothesis. Like most school-based health centers, hers are currently supported by a patchwork of foundation grants, government funding, and fee-for-service reimbursement. Rosenthal believes that all these resources are likely to remain necessary and that health centers will probably never be able to sustain themselves through the revenues they generate.

Hinman disagrees. "Most of these financing mechanisms are not sustainable," he said. "Private foundations typically don't support things for more than five years.

Continued on next page

Bernice Rosenthal, of the Baltimore City Health Department, and Ed Hinman, of THC, jokingly demonstrated the relationship between managed care plans and school-based health centers at the first meeting of the National Assembly on School-Based Health Care in June

HMOs and School-Based Care

Continued from page 3

Congress is cutting these programs out, and states will have to cut them too.

"The public has concluded it wants government out of the direct service business," Hinman contends. "If government isn't going to do it, who will? The only way we'll have school-based health care in the future is if it becomes an integral part of the health care financing and delivery system. And the best way to do this is through managed care."

Regardless of who turns out to be right, at the moment both Hinman and Rosenthal face a critical challenge: working out cooperative agreements with multiple managed care providers competing for market share among the students served by school-based health centers. Rosenthal has been courting other managed care organizations for some time. Now that Hinman is also a school-based health center operator, she anticipates that he will spearhead the effort to bring more managed care organizations to the bargaining table.

At the same time, Rosenthal will be negotiating with Hinman this year for a much broader reimbursement agreement between her school-based health centers and THC. "A meaningful contract," she said, "would mean a fee-for-service arrangement for students who are co-enrolled" and would allow school-based health centers to bill managed care organizations with few restrictions and little pre-authorization.

"In schools with a very significant number of kids enrolled in managed care, I would consider a subcapitation agreement," Rosenthal added, stressing that such an agreement would have to include clear limitations on the school-based health centers' risk for emergency room visits and specialty services.

While Hinman and Rosenthal face a year of thorny negotiations, they are both committed to overcoming any technicalities to make their "marriage" work. They emphasized this commitment when they addressed the National Assembly on School-Based Health Care in June. After playfully donning boxing gloves for a verbal sparring session, Hinman and Rosenthal unveiled matching T-shirts that read, "School-Based Care + HMO = Better."

The Program

Through *Making the Grade*, the Robert Wood Johnson Foundation has funded 12 states to work with communities to plan the delivery of comprehensive school-based health services for children in grades K–12. Of these states, up to 10 will receive approximately $2 million in 1995 to implement their plans.

At the state level, agencies will develop policies that support providing comprehensive primary health care services in schools and that reduce barriers to organizing, financing, and staffing school-based health centers. At the community level, schools, health providers, and representatives of community groups and parents will work together to develop plans for putting in place the comprehensive centers at two or more schools.

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Philadelphia Drafts Guidelines for School-Based Health Centers

The Philadelphia Citizens for Children and Youth, a non-profit advocacy organization interested in children's health issues, developed the following guidelines for school-based health centers. The Philadelphia school district has adopted them as policy. The guidelines, which were drafted with input from the city health department, the U.S. Department of Health and Human Services, child health advocates, and school-based health centers, are intended to aid in the development of school-based health center standards and practices.

1. A school-based health center should accept all children enrolled in the school, including those who are uninsured or enrolled with another provider. Nothing is less supportive of a public health or education agenda than a school-based health center that is open only to certain children. Providers and insurers should work out whatever arrangements are needed for credit, contributions, or intersystem billing.

2. School-based health centers must provide high-quality care. Standards of care must conform to professional medical guidelines and every effort should be made to ensure continuity of care and to avoid duplication of services. All school-based health centers should have a medical professional available by phone on a 24-hour basis; provision should be made to ensure weekend, evening, and vacation coverage for patients. The school district should develop a mechanism to monitor and assure quality health care and to maintain appropriate confidentiality safeguards in school-based health centers.

3. A school-based health center must be responsive to the specific health care needs of the children in the school. Although primary care is a necessity for children, school-based health centers need to recognize that children may have other health care needs, such as dental care, eye care, and mental health care.

4. School-based health centers should support the involvement of parents in their children's health care. School-based health centers must work hard to build family involvement.

5. School-based health centers should not displace educational activities. School-based health centers require a space investment, and that space must not interfere with teaching or learning.

6. School-based clinics should create an environment that supports preventive health care. Schools provide an excellent opportunity to promote good health habits and to integrate health education into the curriculum. This opportunity should not be lost.

7. To be adequately funded, school-based health centers need to be incorporated into a school district design. Systems should be established to make appropriate use of Medical Assistance billing.

8. School-based health center staff should be viewed as part of the school "family." For example, develop health center advisory committees consisting of health center staff, school faculty, administrators, community leaders, and students.

WINTER/SPRING 1996

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Promoting Team Work Among School-Based Health Center Staff

When nutritionist Corie Rheault began working at the Purnell Swett High School health center in Pembroke, North Carolina a few years ago, most of her conversations with overweight teens directed them to change what and how they ate. Last year, however, Rheault spent three days learning about the roles of other health care professionals in the school-based setting where she was reminded that eating disorders can be a symptom of other problems in an adolescent's life, and that a nurse or social worker might also be able to help.

"A person trying to lose weight usually has a psychological or a family problem associated with the weight gain," Rheault said. "So you're going to want the help of a social worker or a psychologist, and then you're going to want to have a medical provider oversee the weight loss. There is a lot of overlapping; you need to know where your profession ends, and when it is time to refer."

The program that taught Rheault to see herself as part of a health care team was funded under a $1.5-million federal training grant for school health staff development. The "School Health Staff Development Priority," which was awarded to 10 states, is part of a larger federal grant program called "Healthy Schools, Healthy Communities." Sponsored jointly by two federal agencies—the Maternal and Child Health Bureau (MCHB) and the Bureau of Primary Health Care—Healthy Schools, Healthy Communities exists to promote community-based systems of care that foster partnerships among the private and public sectors and schools to improve the health of school-age children and adolescents.

To meet the requirements of their grant awards for staff development, each of the 10 grantee states provided a workshop on team building to health center staff and, in most cases, to other members of the school and local community. The participants in the projects also received a short course on how to deal with adolescent health issues, which was something they said they needed help addressing. Some projects included a component to provide training in adolescent health to the teachers and preceptors who prepare health professions students for work in a school-based setting.

Continued on next page

Some Project LEAP participants - a physician assistant, a nutritionist, a nurse practitioner, and a registered nurse - work on an interdisciplinary group exercise as part of the workshop's adolescent health curriculum.

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- National Centers Support School Mental Health
- New Study on Medicaid Billing for IDEA Services

Promoting Team Work

Continued from page 1

The one-year grant program, which ended in October 1995, represented the first nationwide attempt to address a problem that plagues many school-based health centers, said Linda Johnston, MEd, the MCHB program officer in charge of the grant. "You have professionals in the health centers and the schools who just don't know how to work together and don't understand the roles of the different staff people," Johnston said. "We needed an effort to train people to work together toward a common goal."

An Interdisciplinary Education

In Minnesota, school health center staff from around the Twin Cities area attended a team building workshop that was organized last summer by the School Health Interdisciplinary Staff Development Project, which is based in Minneapolis. "I think it is significant that out of the 36 people who participated, 35 said they could now articulate a mission for their health center, after coming in with no clear idea of mission or purpose," said Paula Nelson, a nurse practitioner who was project coordinator and is now the acting adolescent health coordinator for the Minnesota Department of Health.

The Minneapolis workshops were given during a 10-week period that included a three-hour program every Wednesday afternoon and one two-day session for the team-building session. But in North Carolina, the LEAP project (Linking Education and Providers) used its federal funds to bring together school center staff for a four-day retreat. The program also offered participants a course in team-building, as well as "an intensive interdisciplinary curriculum in adolescent health experiences," said LEAP project director Carol Cox. And several weeks after the retreat, LEAP organized two five-hour, interactive televised conferences that included school personnel and health center staff.

Like many of her counterparts around the country, Cox had done a preliminary survey that showed health center staff had not been adequately trained in adolescent health. The information in the survey helped Cox and her colleagues design the interdisciplinary curriculum on adolescent health that they presented during the retreat. "These professionals were not prepared to deal with the violence and family and community issues they were encountering in the school setting," said Cox, an assistant professor at the East Carolina University School of Nursing.

> ***"The staff learned to look at the adolescent as a survivor, and to look for factors that would help a student carry on, in spite of a difficult situation."***
>
> *Paula Nelson*

All of the projects faced the challenge of designing a curriculum that would be relevant to groups that included nurse practitioners, nutritionists, social workers, and health educators. In Minneapolis, one session in adolescent health focused on teaching participants to look for the strengths that would help a student deal with a difficult situation.

"The staff learned to look at the adolescent as a survivor, and to look for factors that would help a student carry on, in spite of a difficult situation," Nelson noted.

Several of the projects addressed the need for training school health providers before they enter the job market. The Maryland staff development project, New Horizons in School Health, organized a two-day preceptor workshop for the nurses, nurse practitioners and social workers who oversee interns in the school health centers. "We are relying more and more on field-based preceptors," said project director Susan Miller, RN, PhD, an assistant clinical professor in the division of adolescent medicine at the University of Maryland. "Academic expectations have changed a lot since these professionals were in school, and they don't get much preparation for the job we are asking them to do."

Johnston cited in particular the creativity with which many of the programs had been designed. Project

Grant Recipients

The following universities and state health departments received school health staff development grants. Workshop curricula and other training materials developed and used by the grantees may be obtained by contacting them directly.

Arkansas Department of Health
Little Rock, AR
Cindy Shelton, 501-661-2000

The Regents of the University of California
San Diego, CA
Howard Taras, 619-552-7680

University of Colorado Health Sciences Center
Denver, CO
Judy Igoe, 303-270-7435

University of Maryland School of Medicine
Baltimore, MD
Susan Miller, 410-328-6495

University of Massachusetts, Dartmouth College of Nursing
North Dartmouth, MA
Patricia Wing Piessens, 508-999-8249

Michigan Department of Public Health
Lansing, MI
Douglas Paterson, 517-335-8928

Minnesota Department of Health
Minneapolis, MN
Donna Petersen, 612-623-5167

East Carolina University
Greenville, NC
Carol Cox, 919-328-4323

Oregon Health Division
Portland, OR
Grant Higginson, 503-731-4021

East Stroudsburg University Health Department
East Stroudsburg, PA
William Livingood, 717-424-3693

CONNECT in Denver, for example, set up a model for distance learning that used satellites and computers to train health center staff in rural Montana. "Doing this involved a collaboration between our school of nursing and our school of engineering, as well as between satellite companies and health and education officials in both states," said project manager Mary Davis of the University of Colorado School of Nursing.

Improving on a Good Idea

Although the federal government has no plans to evaluate the impact of the staff development grant, many of the grantees are working on their own evaluations. LEAP, for example, tested and compared participants' knowledge and attitudes regarding interdisciplinary practice before the workshop, at the conclusion of the workshop, and again six-months later. Cox said the six-month follow-up test indicated a statistically significant gain in knowledge among participants. In addition, in response to an open-ended follow-up question, one of the participants wrote of having gained "increased knowledge, particularly about legal issues, medical issues, complexity of adolescence, school-based health center approaches to care...and greater awareness of programs across North Carolina." Another said that "interdisciplinary management session has led to increased collaboration with student services." Wrote a third, "I encourage you to help us increase our knowledge about adolescent issues. I could never have enough."

Johnston said she wished that the program had been funded for more than one year. A longer time frame would have removed the few obstacles faced by several states in setting up their training programs. "It can take a whole year of working with schools to develop the necessary relationships to make a program like this successful," Johnston said. Several of the projects, for example, were successful in attracting health center staff, but struggled to attract other school personnel. "We did try to get administrators, principals and counselors to come, but the turnout was not what we had hoped," Nelson said. "If we could do this again, we would look at our strategies to get people to come who didn't come this time."

Also in retrospect, Nelson would have made more use of the experienced staff in St. Paul and Minneapolis, many of whom have worked in school health centers for more than 10 years. "We were trying to get people who could meet the needs of the experienced staff who attended the workshop," Nelson said. "But we could have had staff members take a leadership role with some aspects of the program."

Nelson and her colleagues may want to improve on their initial efforts, but Juanita Evans, MSW, chief of the MCHB's adolescent health division could not be more satisfied with the results of the grant program. "We believe this program has been highly successful," she said. "And, despite the loss of the discretionary funds that supported this initiative, MCHB intends to continue supporting school-based health centers through the Title V block grant."

Two National Centers to Support School Mental Health Programs

The Maternal and Child Health Bureau of the U.S. Department of Health and Human Services recently announced that it will fund the development of two national centers to support school-based mental health programs. The five-year grants have been awarded to the University of California, Los Angeles (UCLA) and the University of Maryland at Baltimore (UMB). While each of the centers will have a different focus, together they will provide technical support and training to schools, school districts, and local governments as those entities work to create or improve mental health programs for school children.

"There is a wide range of mental health issues affecting both children and adolescents that schools need to address," said Howard Adelman, co-director of the UCLA center. "But there is no overriding concept or guiding principle to help schools do this. These two centers are intended to help fill that gap. Our services will be available to anyone who is involved with mental health in schools."

The UCLA center, which will function under the auspices of the School Mental Health Project in the Department of Psychology, will focus on mental health policy and practice. The center will address broad systemic issues, including helping localities develop and maintain mental health service programs as well as address the barriers that affect kids' ability to learn. According to Adelman, specific attention will be given to the development of strategies that counter fragmentation of services and enhance school and community programs. Aside from conducting a baseline needs analysis, immediate plans at the center include the development of an online clearinghouse, a newsletter, electronic networking capacity, and continuing education curricula.

"We'll help schools without mental health services develop them, and we'll help schools with such services improve them."

Mark Weist

According to Mark Weist, director of UMB's center, "The role of the Baltimore center is to help school health programs expand and improve their capacity to provide mental health services. We'll help schools without mental health services develop them, and we'll help schools with such services improve them."

More specifically, UMB's Center for School Mental Health Assistance will assess mental health needs in schools, promote the development of a network of school mental health providers, develop and distribute resource materials, conduct staff training, and develop guidelines for mental health professionals who want to specialize in school health programs.

The two centers will work closely together to ensure that their activities are complementary. For more information on the UCLA center, contact Howard Adelman at 310-825-1225 or Linda Taylor at 310-825-3634. For more information on the UMB center, contact Mark Weist at 410-328-3522.

New Study Examines Medicaid Billings for IDEA Services

The MEDSTAT Group of Cambridge, Massachusetts is conducting a detailed national study of Medicaid billings for health-related services provided to disabled children by local education agencies (LEAs). Among the special student populations that some school-based health centers work with are those students eligible for health-related services under the Individuals with Disabilities Act (IDEA), formerly known as the Education for All Handicapped Children Act of 1975. Since 1988, a number of state Medicaid plans have reimbursed LEAs or other providers for medically necessary services that are included in the state's Medicaid plan and are provided to Medicaid beneficiaries by a participating Medicaid provider. Medicaid support for these services has implications for school-based health centers that are collaborating with host schools to provide care as prescribed in a student's Individual Education Plan, a required component of IDEA services.

The report, which will be completed in the next few months, includes policy recommendations as well as case studies of four states that have taken different approaches to the topic. The four states are Massachusetts, Illinois, Louisiana, and Oklahoma. For more information contact Dr. Sally Bachman, project director, The MEDSTAT Group, 617-492-9330.

Making the Grade SBHC Sites

Last May, Making the Grade awarded implementation grants to the states of Colorado, Connecticut, and New York. The states are using their grants to open 16 school-based health centers in eight communities. The centers are located in three high schools, two middle schools, six elementary schools, four consolidated schools (K-12), and one K-8 school. The medical sponsors of the school-based health centers are identified below in bold.

COLORADO
Denver Health & Hospitals
North High School
John F. Kennedy High School

Valley-Wide Health Services, Inc.
Alamosa
Alamosa High School
Saguache County
Center Consolidated Schools

Jefferson County School District
Eiber Elementary
Stein Elementary

CONNECTICUT
Bridgeport Health Department
Dunbar K-8 School

New Haven Public Schools/ Fair Haven Community Health Center
Sheridan Middle
Clinton Avenue (K-4)

NEW YORK
Comprehensive Adolescent Services
Binghamton
Franklin Elementary
Roosevelt Elementary

Sunset Park Family Health Center/ Lutheran Medical Center, *Brooklyn*
P.S. 10 Elementary

Long Island College Hospital
Brooklyn
Middle School 51

Mary Imogene Bassett Hospital
Cooperstown
Edmeston Consolidated
Morris Consolidated
Laurens Consolidated

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Publications Available from Making the Grade

Reprints of the following articles:

"Back to School: Training Opportunities in School-Based Health Care." L. Jusczcak et al. *Journal of Behavioral Pediatrics,* vol. 16, no. 2 (April 1995).

❖

"School-Based Health Centers: A Select Bibliography." *Journal of Adolescent Health,* vol. 17, no. 2 (August 1995).

❖

"Key Issues Affecting School-Based Health Centers and Medicaid." *Journal of School Health* vol. 66, no. 3 (March 1996).

❖

"State Initiatives to Support School-Based Health Centers: A National Survey." Schlitt JJ et al. *Journal of Adolescent Health,* vol. 17, no 2 (August 1995).

Monographs:

Financing School-Based Health Centers: A Guide for State Officials. Making the Grade National Program Office and Rosenberg & Associates, September 1995.

❖

Medicaid, Managed Care and School-Based Health Centers Proceedings of a Workshop. Making the Grade National Program Office, August 1995.

❖

SUMMER 1996

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Louisiana's School-Based Health Centers Secure $2.6 Million Annual Appropriation

When Louisiana Gov. Mike Foster (R) signed into law the state's $12.1 billion operating budget for the fiscal year that began July 1, proponents of school-based health centers in the state celebrated a major success: a new $2.65 million line item. School-based health centers had received state funding in previous years — a $1.6 million line item in 1994 and some "below the line" funding, or funding that is not explicitly stated in the budget, in 1995 — but this new line item, which is authorized annually, is a significant budget increase for the centers.

The line item was one of the most heavily debated subjects of the legislative session, in which school-based health centers faced accusations of violating the state's ban on abortion referrals and distribution of contraceptives.

In the end, an overwhelming majority of lawmakers found those accusations baseless and sent the budget on to Foster with the line item intact. Moreover, the Senate passed a non-binding resolution urging the governor not to veto the line item.

Inside this Issue

- State Leaders Change; Support for SBHCs Remains
- Report on NASBHC's June Conference
- 100% Parent Support– SBHC Enrolls All Students

But Foster, who was elected last fall, was concerned about the accusations, and wanted to make sure that the centers were indeed in compliance with the law before approving the funding. Press headlines at the time indicated that Foster was inclined to veto the line item.

Foster's ultimate decision to fund the centers boiled down to two factors, according to Andy Kopplin, special assistant to Foster for policy and planning. First, the centers and their advocates were able to show their commitment to and "vigilance" in following the law. Second, "there were enough community members who were familiar with the work the centers did and who could credibly make the case that they were providing valuable services, that they were following the law, and that if they weren't [following the law], they should be shut down," said Kopplin.

Louisiana Governor M.J. "Mike" Foster, Jr.

Eight-Year History Wins Governor

Foster, said Kopplin, had to satisfy himself that the centers were doing what they were supposed to be doing. At the same time, the governor felt strongly that the centers were providing sorely needed health care services to school children, many of whom were low-income and underserved, and that "we ought not to be taking health care away from them," Kopplin said.

In fact, Foster was persuaded by the basic message that the centers have been demonstrating in their communities about the importance of child and adolescent health and the value of the services they provide. The message about these services reached Foster through lawmakers on both sides

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Louisiana's Health Centers

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of the political aisle, through lobbyists representing health care and children's advocacy organizations, through religious leaders, local politicians, business leaders, parents, teachers, the news media — in short, just about anyone who was familiar with the centers and the work that they do.

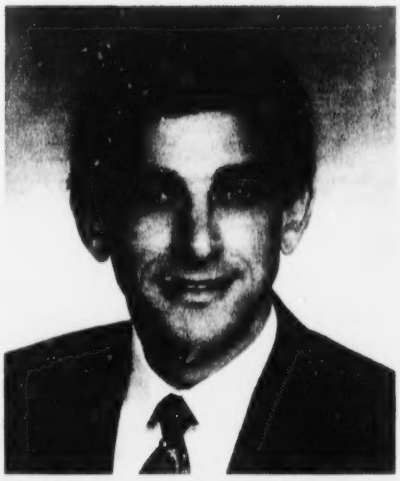
"The coalition for school-based health centers has been building for eight years," said Sylvia Sterne, director of adolescent and school health for the Louisiana Office of Public Health. "People have had a chance to see their benefits." By the time the line item became an issue, "there was so much support that had already built up for the centers, and it became such a visible thing that it had taken on a life of its own," she added.

It's important to stress that the widespread grassroots support that enabled the centers' advocates to overcome their opponents' accusations did not develop overnight in a time of crisis; it was planted on Day One and nurtured diligently over the long haul. It starts, said Sterne, with running a good program that is responsive to local needs and then inviting people from all sectors of the community to see firsthand how the program operates and what it accomplishes.

Communications Played Key Role

During the past two and a half years, the Louisiana Adolescent School Health Initiative has stepped up its communication efforts as part of its participation in Making the Grade. "We found that our biggest challenge was overcoming misinformation at the local level," said Cheron Brylski, a consultant to the Louisiana Adolescent School Health Initiative. "Nevertheless, as we tried to seek budgetary commitment to the program from the state of Louisiana, we noticed that there was also a lot of misinformation about the program at the state level."

To combat that misinformation, "we sought the help of advisory committee members and some very simple fact sheets that explained what school-based health centers do," Brylski explained. In addition, "we constantly built up our factual base. We did statewide surveys, we documented why students used our school-based health centers, we compiled that information, and we distributed it to the public, the media and the legislators."



Louisiana State Senator Jay Dardenne

The health center managers described their mission to provide essential primary and preventive health services. Reproductive health issues account for less than five percent of total visits to school-based health centers, which refer students who come in for those reasons to appropriate outside medical professionals. Health center managers also pointed to a study that gave Louisiana the lowest national composite score among all 50 states for child and adolescent health. That score took into account health indicators such as low birth weight, infant mortality, deaths among children aged 1-14, teen deaths due to automobile accidents and violence, and births to teenage mothers. In addition, at that time, Louisiana's school drop-out rate was the highest in the country.

Sterne recalled that opposition first became visible two years ago when full-page ads appeared in at least one local newspaper claiming that the health centers would be forced by the federal government to perform abortions, hand out contraceptives, and diminish parents' rights over their children. Sterne's response was simple: she sat down with a piece of paper. On the left side of the paper, she wrote down each "myth" from the ad, and on the right, "I put the fact. I told them the truth about what communities were doing." She made copies and sent them to everyone involved with Louisiana's school-based health centers. "Once we understood what opponents were saying, we were able to respond to them with the truth," Sterne said.

Support for school-based health centers cuts across all geographic areas of the state, all socio-demographic classes, and all political affiliations. "This was a proactive campaign that was enhanced by a strong community base — strong enough to convince the legislators that there was support for this idea," said Leslie Gerwin, another consultant to the Adolescent School Health Initiative. The legislators who believed in the program's merits became its most important champions in the State House. "The legislators themselves were the most important advocates for the line item," observed Brylski. "They were the ones who argued the case for school-based health centers on the floors of both houses, and that's important, because we cannot lobby. In the best grassroots fashion, our local school-based health centers had taken the time to educate these people, and it paid off in a very big way."

State Sen. Jay Dardenne, a Baton Rouge Republican and the governor's floor leader, was one of those advocates. He and other lawmakers encouraged Foster not to veto the line item, although Foster was under considerable pressure from the Christian Coalition to do just the opposite. "In the end," said Dardenne, "I think the governor satisfied himself that the concerns were unfounded, that the programs were meritorious, and that the clinics were serving a valuable health care need in our community."

Dardenne notes that he has had a generally good relationship with the Christian Coalition, which last year gave him a perfect score for his voting record. "But I disagreed with them on this issue," he said, adding that he's been supportive of school-based health centers for some time and has access to firsthand information because of his wife's involvement in the Baton Rouge program's community advisory board. "I felt very comfortable with the good work that they were doing and was also quite satisfied that the concerns of the coalition were not valid," he said.

State Rep. Renee Gill Pratt, a Democrat from New Orleans Parish, gave the governor her input as well, stressing to him the importance of the health centers' work and her certainty that they were not violating the law. Pratt too had firsthand knowledge because of her job as a compliance

monitor for the parish school system. She agreed with Dardenne that the crucial factor for Foster was "knowing that the clinics were truly serving their purpose and weren't giving any information on abortion."

Meanwhile, many of the newspapers in the state published editorials backing the health centers. One paper even supplied readers with contact information for Foster's office. "I don't know of any press that did not support the health centers," reported Sterne. Brylski noted that the program has always maintained an open-door policy with the news media and tries to keep them informed of new activities or developments, even when that information does not generate news coverage.

Increasing support for the health centers also came from lobbyists for other groups. Among the most active groups, recalled Sterne, were Louisiana's Maternal and Child Health Coalition, the Agenda for Children, and a number of hospitals, including several Catholic institutions.

Foster's office was overwhelmed by phone calls, letters, and faxes from people on both sides of the issue, but the majority, recalled Kopplin, came from people who backed the health centers.

According to Sterne, the line item will enable the Louisiana Adolescent School Health Initiative to expand its comprehensive school health program, open new health centers, and introduce more services into existing centers. In addition, said Sterne, the Initiative will continue to do what it's been doing all along: providing good services that are wanted and needed by local communities. That, she said, is the key to the program's survival — and its continued growth.

Leaders Change; Support for SBHCs Remains the Same

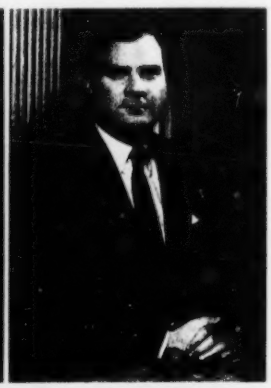
In November 1994, the leadership of a number of states with well-established school-based health center programs changed. Of the 10 states with the largest school-based health center funding (see table), only two — Arkansas and Delaware — experienced no turnover in political control in either the governorship or legislature. To date, these changes in leadership have not reduced state support for school-based health centers.

Connecticut and New York, two pioneers in school-based health care, were among those experiencing the most dramatic political changes. In New York, Governor Mario Cuomo (D) was succeeded by George Pataki (R). And in Connecticut, Governor Lowell Weicher (I) was succeeded by John Rowland (R). Despite initial anxieties among school-based health center supporters, both states have maintained their commitments to the centers and extended state support into new areas. Not only has funding survived a period of fiscal belt-tightening, the new state leaders have included the centers as part of their plans for Medicaid managed care, and have launched aggressive programs to strengthen the centers' clinical programs and facilitate their participation in managed care provider networks.

"School-based health centers offer an important opportunity for the state, in partnership with local government and community health care providers, to assure the availability of services to children in need," said Connecticut Governor John Rowland.

"School-based health centers are a key component in New York's efforts to improve the health of children and families," said Governor George Pataki. "Approximately 150,000 New York children rely on school-based health centers for primary health care needs."

NY Gov. George Pataki



CT Gov. John Rowland

Even without changes in political direction, the election of new leaders or the appointment of a new agency head requires that school-based health center programs make sure that the services of the centers are known and understood. The inevitability of changes in administrations and political party control and the importance of sustaining support through those changes has led Making the Grade state directors to emphasize information-sharing and communications. For example, to foster relationships between centers and lawmakers, Lynn Noyes, Connecticut director, suggests inviting government officials to visit local centers to tour the facilities and meet parents.

Sylvia Pirani, New York coordinator, said that to be effective, school-based health center programs must reach out to a variety of constituencies and different organizations. "Support for children's services comes from all parts of the political spectrum and support for school-based health centers can be equally broad," she said.

SBHC Funding Leaders: The Impact of Political Change

State	'94 Funding* (in millions)	'96 Funding* (in millions)	Change in party control** (Governor and/or legislature)
Arkansas	$1.0	$1.0	No Change
Connecticut	4.0	3.8	Change
Delaware	1.6	2.9	No Change
Florida	1.4	1.5	Change
Illinois	1.4	1.4	Change
Louisiana	1.1	1.4 (2.6 in '97)	Change
Massachusetts	1.5	2.3	Change
Michigan	2.6	2.9	Change
New York	10.0	10.0	Change
North Carolina	.9	1.0	Change
Texas	2.0	2.0	Change

*State general funds and/or health block grant dollars. ** All elections were in 1994 except Louisiana, which was in 1995.

Standing Room Only at National Assembly Meeting in Baltimore

The National Assembly on School-Based Health Care held its second annual conference in Baltimore, June 26-28, 1996. The conference drew 675 participants from 43 states. The largest delegations came from Maryland (127), New York (53), Texas (40), Massachusetts (34), California (32), Connecticut (31), and Delaware (26).

Martee Engel (Rusk Health Promotion Project, Spring, Texas) presents incoming National Assembly president Jacob Moody (Balboa Teen Health Center, San Francisco) with an official Texas Association of School-Based Health Care T-shirt.

Michael Godfrey (Los Angeles Unified School District) addresses the National Assembly about California's efforts to create a state chapter. Other states reporting on state chapter activity included Colorado, Louisiana, New York, Pennsylvania, Texas, and West Virginia

Kate Conway (Henry Ford Health System, Detroit) introduces newly elected section chairs to the Assembly members.

Membership committee co-chair Tamara Copeland (National Health and Education Consortium, Washington, DC) presents a proposal to revise the membership structure.

Lift Every Voice and Sing

In his inaugural address to the National Assembly on School-Based Health Care, Jacob Moody, incoming president, drew lessons and insights from the Hartford Heights Elementary School choir whose performance had opened the conference.

Did you look at their faces? Did you see the faces of the children you serve? And did you hear our hopes and fears in the songs they sang? The themes they raised — love, loss and disappointment, and hope — aren't they *our* themes?

Did you see the energy that choir had? It reminded me of the energy I have experienced from everyone at this conference. You are energized by your love of children. It's clear. And more than that, it is clear you respect them as unique and unrepeatable gifts to history. This love that you have for them is dynamically present in your willingness to enter into relationships with them. You put yourself out to them, and they respond. You let them know that you have a stake not only in the quality but the quantity of their lives, and you allow them to form that very same stake in your life.

But as you create that relationship, not only with the children but also with the adults you work with who also love children, you take a risk. The risk is that loss and disappointment are possible. Their song said, "No one here can love or understand me. Oh, what hard luck stories they all hand me." Wasn't that ironic — to look at all those little faces and hear them say that? *That* is what the world tells them. Do you realize that when they sang that song, they told us their experience? And their hard-luck stories are the stories they are told when the world says it's *their* fault things aren't going well for them. Eight-years-old and it's their fault.

At that moment I wanted to say, "we'll be there; we'll stand with you." That's what this organization is about — being there for children. But we know that many of the people and systems that these young people encounter do not and will not care for them. But we cannot be discouraged — no matter what happens to our budgets, our issues, our ideas. We have no reason for despair because hope is alive. And we saw it in the Hartford Heights Elementary School choir.

Now I don't know about you, but I could see the face of the choir's director. This man — Charles Arnett — could do four amazing things at once. First, he was playing the heck out of that piano; second, he was singing the words with the choir. Then he did something — and I don't know how he did this — in the midst of the playing and singing, he was encouraging them, urging them to smile, to be out there. And if that weren't enough, there were some in the choir who were not behaving according to choir etiquette, and he was disciplining them. It was amazing — playing the piano, singing, urging them on, *and* admonishing them. But those kids responded. They were connected to each other, and their connection gave them power and possibility. Together they were more than any of them could be separately. And because they were together, because they had chosen one vision and one goal, success was possible.

It reminded me of this group — how clear and distinct all of you are in the work you do. And yet, how together we are one, moving forward. What we saw embodied in that choir was hope, power, and possibility. And that hope, power, and possibility are ours. Together, like Charles Arnett and his choir, we can do at least four amazing things at once, and the children we love will join with us in their doing.

Incoming National Assembly president Jacob Moody addresses a capacity crowd at the annual meeting

Tielhard de Chardin said it best: "The task before us, if we would not perish, is to shake off our ancient prejudices and build the earth." We are on the way. We can do this.

Making the Grade

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If You Build It, They Will Come

Joe Sandoval, principal at North High School in northwest Denver, thought he and his colleagues did a pretty good job assessing the need for a school-based health center to serve the school's largely Hispanic student population. But even Sandoval was surprised at the parents' response upon the opening of the center last fall: 100 percent of the student body was enrolled with signed parental consent.

"We were overwhelmed," said Marlene Yaniglos, pediatric nurse practitioner and health care provider at North High, "and a little gratified to know our careful planning paid off." Yaniglos and Sandoval were meticulous in working with the school and other interested constituencies to prepare for the opening. "We presumed the students and their families would welcome the health center," said Sandoval. "We knew there was an enormous need. Our first concern was to ensure the buy-in of the faculty and staff, to create a welcoming atmosphere for the health center."

A key to the center's early success was the preparatory work done prior to the center's opening. "Our goal was unanimous support," said Yaniglos. "We involved several of the school departments in putting together a needs assessment and collecting the data. Coaches became interested because of the potential for on-site sports physicals. Center staff held open houses and potluck dinners for teachers and provided routine updates at faculty meetings. The assistant principal met weekly with the health center staff."

And the phenomenal parental enrollment? Sandoval gets credit for a unique registration process at North High that requires parents to accompany their children at school enrollment. The school-based health center is one of the many stations of the enrollment process through which parents and students must pass. After being informed about the center, parents are given consent forms that they may sign on site. Yaniglos also credits the bilingual staff at the registration tables who helped bridge language barriers: "The staff were there to respond to the families' concerns." Most importantly, parents took the opportunity to sign up their children that evening, which effectively reduced the potential for lost or unreturned consent forms.

The efforts of the principal and practitioner are paying off. Within the first six months, nearly 1,900 visits — an average of 14 per day — were made to the center. The full-time staff includes nurse practitioner Yaniglos, a substance abuse counselor, mental health provider, and health technician; a physician's assistant and medical doctor provide part-time support. Rounding out the team from the school's pupil service staff are a social worker and psychologist. While the students come to the center with mostly minor ailments, the screening that results from these visits is a valuable opportunity to reveal greater needs. The students may come through the health center door with stomach pain and head aches, but the staff are discovering more significant issues related to family, peer, and school relationships. As students come to find the services accessible and user-friendly, center staff find some of the days can be long. "It isn't easy to tell a child who comes to you at the close of business hours, 'Come back tomorrow,'" said Yaniglos, "it just can't be business as usual."

A GUBERNATORIAL VISIT

Guided by students, Colorado Governor Roy Romer tours the school-based health center at Lincoln High in Denver.

Pediatrics Journal Features Health Care in Schools

"Health Care in Schools" is the subject of the June 1996 issue of Adolescent Medicine: State of the Art Reviews (AM:STARs), which is the journal of the American Academy of Pediatrics' Section on Adolescent Health. The 180-page issue was edited by Linda Juszczak, MS, MPH, CPNP, and Martin Fisher, MD, both of North Shore University Hospital in Manhasset, New York. Published three times a year, single issues of AM:STARs are available for $33. To order, call Hanley & Belfus, Inc. at 1-800-962-1892.

FALL 1996

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

School-Based Health Centers Continue to Grow

Data from Making the Grade's most recent survey of state initiatives to support school-based health centers (SBHCs) reveal that more than 900 centers provided care to children during the 1995-96 school year. This represents a 50 percent increase over the Making the Grade survey conducted two years earlier.

State Support Remains Key

State governments continue to provide substantial funding for the centers. During 1995-96, 34 states allocated

Continued on next page

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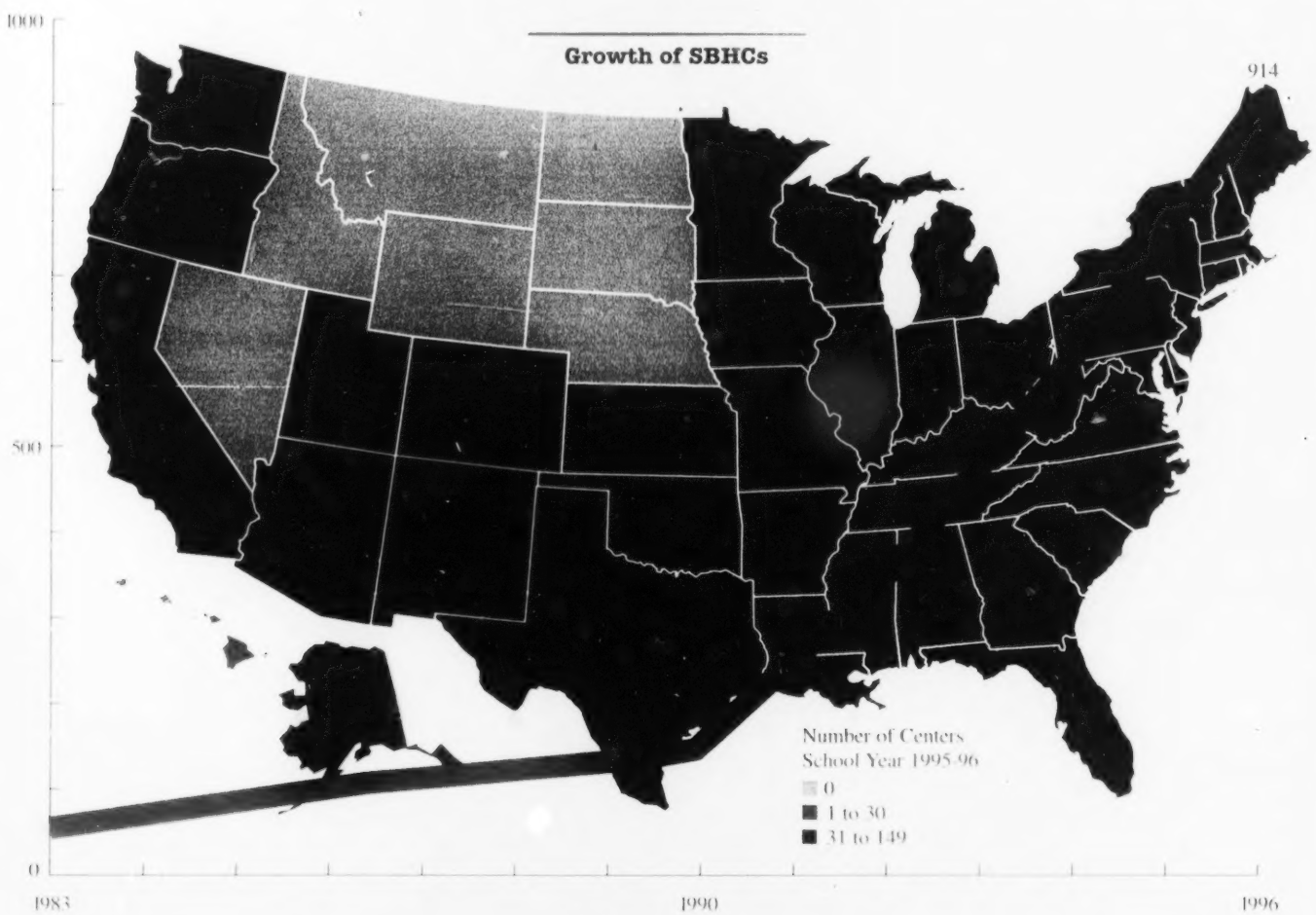
- More Hospitals are Sponsoring SBHCs
- Making the Grade Web Site



$41.9 million in state and federal block grant funds to school-based health centers, an eight percent increase over 1994. Fifty-four percent of all school-based health centers received some state-directed funding. This means that for every two SBHCs, one is receiving some degree of state support.

The portion of the center budgets supported by state-directed dollars varies greatly. Twelve states supported at least 75 percent of their centers and of those, four states supplied over 90 percent of the total funds needed to run those centers. Five states reported that fewer than half of their centers received any state-directed funds, and ten states provided no state-directed funding.

The primary sources of state-directed support are Title V of the Social Security Act (Maternal Child Health Block Grants) and state categorical funds. Other sources of federal support include the Social Security Block Grant, the Preventive Health Block Grant, and Drug Free Schools and Communities Act. Most states have not tracked financial support available through Medicaid reimbursement, but patient care revenues from a variety of payers, including Medicaid, appear to be an increasing source of funding.

Five states account for nearly three-fourths of the $13 million in Title V monies: Georgia, Illinois, Louisiana, New York, and Texas. Six states account for over 80 percent of the $27.7 million in state revenues. They are: Arizona, Connecticut, Delaware, Florida, Massachusetts, Michigan, and New York.

Centers Spread South and West

Two years ago more than half of all SBHCs were located in the Northeastern and Mid-Atlantic states. Recent growth in Florida, Texas and Arizona has reduced that proportion to 43 percent. The growth outside the Northeast indicates the national appeal of this model. In 1996, school-based health centers were distributed as follows: Mid-Atlantic states and New England, 379; Southeast and South-central states, 181; Midwest, 109; Southwestern and Rocky Mountain states, 164; and Pacific coast states, 79.

As the map indicates, school-based health centers are found in 43 states plus the District of Columbia. The ten states reporting the largest number of centers are: New York, Florida, Texas, Connecticut, Pennsylvania, Maryland, California, Massachusetts, Oregon, and Michigan.

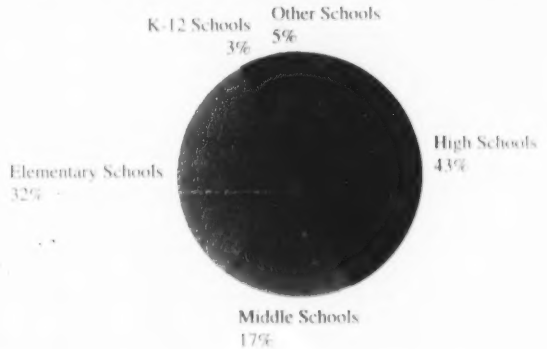
As states with significant efforts to improve rural health become involved in school-based health care, the number of rural schools offering primary care services has expanded. School-based health center programs in West Virginia, North Carolina, and Louisiana particularly have contributed to the increased presence of SBHCs in rural areas of the country.

School-based health centers continue to be located in all types of schools. While high schools remain the primary site of SBHCs, at 43 percent of all centers, elementary schools now house 32 percent of the centers and middle schools house 17 percent of the centers. Three percent of the centers are located in comprehensive K-12 schools, and five percent are located in other types of schools, including alternative schools, K-middle schools, and Head Start programs. Compared to two years ago, a larger proportion of the centers are serving elementary and middle school students — increasing the importance of health promotion and preventive services.

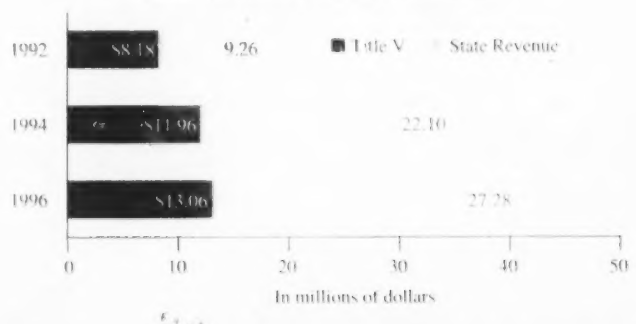
Survey Criteria

To be included in this survey, school-based health centers met the following criteria: the centers were located on school grounds and were staffed at a minimum by a primary care provider (ARNP, PA, or MD). Centers with a primary care provider on site 25 hours a week or more were classified as full-time. Sixty percent of the 914 centers were identified as full-time.

Types of Schools Housing SBHCs, Nationwide



State-Directed Funding for SBHCs



Altruism and Fiscal Incentives Drive Hospital Involvement with SBHCs

It is not unusual for a school-based health center to be sponsored by a health care organization. Until recently, however, such sponsors typically have been community health centers or public health departments, not hospitals. While some hospitals have been involved with school-based health centers for years, more and more hospitals are beginning to invest energy into the endeavor. In fact, all of the hospital-sponsored school-based health center programs profiled below are only a few years old.

What is driving hospitals' growing interest in school-based health care as well as other community-based initiatives? Simply stated, the hospitals that are sponsoring school-based health centers view them as a way to increase access to primary and preventive health care in their respective communities, and thereby improve the health status of school-age children and reduce the chances that those children will require more costly acute care at a later date.

"There are two main reasons why we became involved with school-based health centers," said Kathleen Conway, director of the School-Based Health Initiative for the Henry Ford Health System in Detroit, Michigan. "One is altruistic: this is the community in which we [health system employees] live and work, so as responsible citizens, we must help solve the problems in the community. The other reason is the health system's bottom line. We must encourage people to use the system correctly, and to not use the emergency room for non-urgent care. If that means helping people access preventive care closer to home, then that's what we must do."

Conway's words were echoed by Wil Trower, CEO of the North Broward Hospital District, which sponsors eight school-based health centers in Broward County, Florida: "We've found that the uninsured and underinsured populations in our county are growing much faster than our ability to keep up with their acute care needs. We created school-based health centers to allow us to deliver more primary and preventive care and keep kids out of the emergency room."

A Variety of Funding Strategies

In this era of cost-conscious competition in the health care delivery system, all hospitals, whether possessed of a community-based mission or not, must wrestle with difficult financial constraints. The hospitals that sponsor school-based health centers rely on a number of different funding sources including special tax dollars, patient revenues, and public and private grant funds. Many hospitals also are actively engaged in exploring the possibility of third-party billing to help support their school-based health centers.

"We created school-based health centers to allow us to deliver more primary and preventive care and keep kids out of the emergency room."

Wil Trower

The North Broward Hospital District, which was created by the Florida legislature in 1951, is a system of four non-profit medical centers and their satellite facilities that are supported, in large part, by a special health care tax levied on homeowners in the county. Such special taxing districts are common in Florida, which does not have a state income tax. In 1996, the hospital district, which is charged with caring for those who can not pay for care and is directed by a Board of Commissioners appointed by the governor, provided approximately $1.4 million to support eight school-based health centers. The school-based health centers also receive substantial funding from the county school board.

"The more we can prevent these kids from having to come to our hospitals for basic health care, the more effective we are as stewards of the public's tax dollars," said Trower. "Providing primary care and prevention services in the community allows us to broaden our reach and, in essence, get more bang for the public buck."

According to Anne Platt, manager of the School Health Program at North Broward, the hospital district, which created one school-based health center in 1993, one in 1994, and six more this year, is already seeing results. "At the older sites, we have seen an increase in school attendance, improved immunization rates, and an increase in the number of students receiving physicals," she said.

Possessed of a community-based mission but no special tax dollars, Parkview Episcopal Medical Center in Pueblo, Colorado is sponsoring a school-based health center in one of the city's four high schools in partnership with the local school district.

"Originally, School District 60 applied for a state grant to create a school-based health center at Central High School, but they were turned down," said Eileen Dennis, vice president of Patient Services at Parkview. "When that happened, the school district came to us and asked for our help. Our CEO saw this as an opportunity to really solve problems."

Opened in Fall 1995, the school-based health center serves 85 percent of Central High's student population. During the first year of operation, the hospital spent approximately $150,000 to support the comprehensive health center as well as an auxiliary program that sends nurse practitioners to two middle schools. As is the case with most hospital sponsorships of school-based health centers, much of the support was supplied in the form of health center staff and equipment.

"We're estimating that this is an on-going expense of about $100,000 a year, which comes straight out of the hospital bank account," said Dennis. "We'd love to expand our involvement, so we're looking at ways to raise money, including the possibility of third-party billing. We've had some real interest from HMOs."

Employing Outside Resources

Grant support from both private and public entities, such as foundations and state governments, is another source of funding relied upon by hospitals involved with school-based health centers. For example, the Henry Ford Health System in Detroit, which is anchored by the Henry Ford Hospital, is creating school-based health centers with grant funding from the W.K.

Kellogg Foundation. Specifically, Kellogg awarded $4 million to Henry Ford in 1994 to support school-based health care programs in 13 Detroit public schools. School-based health centers will be supported in 10 of the 13 schools. Currently, five centers are completely operational and five more centers are in various stages of development.

"The initial Kellogg grant will support this effort at least through 1998," said Henry Ford's Conway. "But we're currently engaged in looking for other sources of support that will continue past that period. To that end, I've been involved in developing partnerships with other hospitals in the area to assume responsibility for one or more of the school-based health care programs. So far, we've been very successful. In addition to the five schools that Henry Ford will support, six programs have been partnered with other hospitals, which now receive part of the Kellogg money. Those hospitals have made a commitment to continue the school-based programs after the grant money runs out."

The W.K. Kellogg Foundation, which supports eight different initiatives that involve the creation of school-based health centers, is one of many private sources of grant funds that are helping hospitals create such centers. The Duke Endowment, which limits its grant-making to non-profit hospitals in North and South Carolina, has made an institutional commitment to school-based health and, to date, has awarded about $2 million to support the creation of school-based and school-linked health centers in those states.

The Hospital Research and Educational Trust (HRET), the research and educational affiliate of the American Hospital Association (AHA), is supporting the creation of 12 school-based health centers through its National Community Care Network Demonstration Program, which is intended to encourage community-responsive health care delivery reform. The program, which was funded by $7 million from the W.K. Kellogg Foundation and the Duke Endowment, is a collaborative effort of HRET, AHA, the Catholic Health Association of the United States, and the Voluntary Hospital Association Inc.

Many hospitals and their community partners also are relying on grants from state and local governments to help support school-based health centers. In Evanston, Illinois, the city's sole school-based health center is sponsored by a community partnership that includes the city, the local high school, and a local hospital. The partnership is funded by a five-year state grant, which began in February 1996.

"We have an active community advisory board for the school-based health center," said Susan Nelson, clinical director of ambulatory services at Evanston Hospital. "One of the subcommittees is focusing on development and fundraising activities so that we will be able to remain operational at the end of our grant. There is a strong commitment on the part of all three partners to keep this center going. The center just opened in February and we can already see what a positive difference it has made."

At a time when all health care providers are being called upon to become more focused on their communities, school-based health centers are a good fit for hospitals. "School-based health centers are a natural bridge between the community and the delivery system," said Mary Pittman, president of HRET. "By building a bridge, health care can be made more cost-effective and community health can be significantly improved."

Making the Grade

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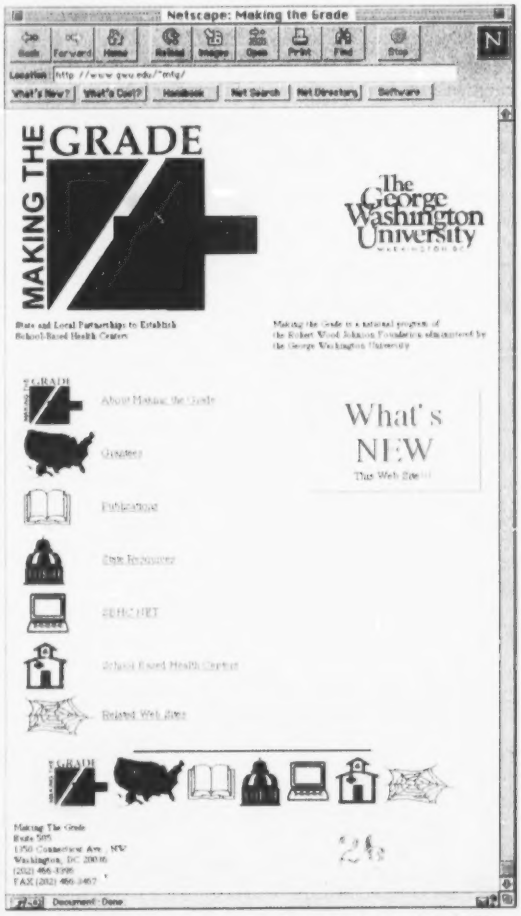

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SPRING 1997

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Taking Stock of School-Based Health Centers

Do school-based health centers work? It is a fair question—one that is being asked across the country by state legislatures, health insurers, communities, and others who are looking for ways to increase access to health care for youth while keeping costs down. It is also a difficult question to answer, according to many of the researchers who have dedicated time and energy to it.

First, there is a semantics problem. How do we define the term "work?" If we mean: "do school-based health centers increase access to health care for school-age kids?," then the probable answer is yes. If we mean: "do school-based health centers reduce teen pregnancy rates?," then the probable answer is no. Clearly, the answer depends upon how the question is phrased and what the question intends.

And what about the term "school-based health center?" Currently, school-based health centers vary in many ways including scope of services provided, number and types of professional staff, school settings, and hours of operation. This variation makes it difficult to compare the results of different studies. Then, there is always a question about whether or not the design of any given study is scientifically sound. To date, few school-based health center studies have been done using rigorous designs that result in reliable findings. Such studies are difficult to conduct for many reasons: they are expensive; they require school, parent, and student consents; and they require tracking students who are highly mobile. More common than long-term research studies are program evaluations, which typically use less rigorous study designs to assess the impact of a particular school-based health center or group of centers on students.

But these issues do not make the question—do school-based health centers work?—any less salient. Nor do these issues mean that researchers are not trying to answer the question. Researchers are circling around this broad question with specific studies. With each new program evaluation and research project, they are building a case for school-based health centers.

"Intuitively, we know school-based health centers are a good thing because we're bringing health care to kids who don't usually receive it, but intuition doesn't get the bills paid," said Robert Nystrom, a coordinator for the school-based health center programs for the Oregon Health Division, and co-chair of the research and evaluation section of the National Assembly of School-Based Health Care. Nystrom recently worked with researchers in Oregon to conduct an evaluation of school-based health centers and report on the status of adolescent risk behaviors in the state. The results will be compiled into a statewide report this spring.

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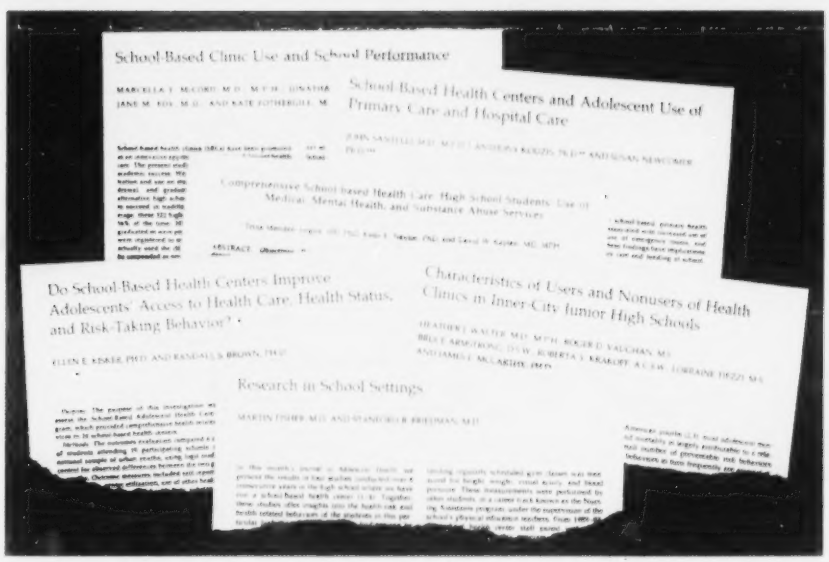
School-Based Clinic Use and School Performance
School-Based Health Centers and Adolescent Use of Primary Care and Hospital Care
Comprehensive School-based Health Care: High School Students' Use of Medical, Mental Health, and Substance Abuse Services
Do School-Based Health Centers Improve Adolescents' Access to Health Care, Health Status, and Risk-Taking Behavior?
Characteristics of Users and Nonusers of Health Clinics in Inner-City Junior High Schools
Research in School Settings

A small sample of peer-reviewed journal articles relating to research, evaluation, and school-based health centers.

Inside this Issue

- Comprehensive SBHCs
- Study Examines Teens' Use of SBHCs and HMOs
- HMO-SBHC Partnership to Care for Uninsured Kids

What Do We Know?

Summarizing what is known about school-based health centers is tricky. As with all research, initial findings are never definitive because they may be contradicted by subsequent studies. Still, researchers are willing to make qualified statements regarding "what we know" about school-based health centers.

"We have some idea about the impact of school-based health centers based on the research literature," said John Santelli, MD, MPH, a medical epidemiologist at the Centers for Disease Control and Prevention and published author of several school-based health center studies. "There is evidence that the centers increase kids' utilization of primary care services. There is also evidence that school-based health centers attract higher risk kids. A number of studies suggest that both parents and students are satisfied with the care provided in school-based health centers.

"While there is some evidence of displacement effects, meaning kids use school-based health centers in place of community providers, there also seems to be a net gain in the total number of provider visits," he said. "Kids who have access to a school-based health center tend to go for health care more often than they do if they only have access to a community provider. There is some evidence that centers reduce emergency room use and hospitalization rates, but little evidence that they reduce risk-taking behaviors."

We don't know more than we do about school-based health centers because there are numerous barriers to conducting the necessary research, according to Martin Fisher, MD, chief of the division of adolescent medicine at North Shore University Hospital on Long Island, NY, and medical director of the Far Rockaway School-Based Health Center Program. "We're being asked to prove large changes in small populations," he said. "If you think about the student population of a school, it's relatively small. Although 80 percent of the school population may be enrolled in the school-based health center, typically about half of the school population uses the center. School-based health centers do a large amount for a small subset of students that have specific health problems and a small amount for the large number of students who are basically healthy. This makes it difficult to show a difference between having a center and not having one in any given community.

"Other barriers include the changing population. Because it's a school population you always have kids coming in and going out, so it's difficult to do longitudinal studies," Fisher said. "It's also very difficult to answer the 'what if we weren't here?' question because the study design would require two parallel schools, one with a school-based health center and one without. That's very hard to do both politically and logistically. No two schools are exactly alike. Also, it's difficult to define what outcomes you're looking for in any particular study. School-based health centers deal with complicated psycho-social problems. Measuring outcomes related to risk behaviors is pretty sophisticated."

"We need large national studies that carry enough statistical power to give us the outcomes answers we're looking for..."

Jonathan Klein

Many of the difficulties associated with school-based health center research are apparent in the literature. For example, the evaluation of 19 school-based health centers funded by the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program offers some valuable lessons to researchers. The evaluation found that school-based health centers could increase access to care for adolescents, but it did not document an impact on risk behavior. The Foundation's initial evaluation design had to be changed part way through the program. The original design involved comparing the 19 school-based health center schools to 19 matched schools without school-based health centers.

"The original design was problematic," said Marjorie Gutman, senior program officer at the Robert Wood Johnson Foundation. "Starting up the centers was already controversial in many of the communities. The Foundation was worried that the communities would react further to the collection of sensitive information from kids in additional high schools. So we dropped the comparison schools and decided to do a national telephone survey of low-income, urban adolescents who would provide a reference sample for the school-based health center population – not a precisely comparable group but close enough to make some assessments of similarities or differences between the teen sample and those using the school-based health centers."

Where are We Headed?

School-based health center research has moved through several phases in the past decade, according to North Shore's Fisher. "We started out in the 1980s doing research on whether or not school-based health centers can have an impact on risk behaviors," he said. "But we found that we weren't really having an impact, largely because most programs weren't set up to address such specific needs. So we moved to the next level of research: looking at comprehensive care and documenting that school-based health centers could deliver primary care and be accepted by students. In the early 1990s, we moved on to a third level. We understood that the centers could provide important basic health care services to adolescents, but we wanted to know which ones. Who are we helping? Who's using our services? And today, we're at yet another level of research. We're trying to demonstrate the exact efficacy of school-based health centers by documenting specific outcomes and looking at cost-benefit ratios. This level of research is in keeping with what's going on in all of medicine. We're all having to prove our worth."

Proving the worth of school-based health centers is essential to ensuring a place for school-based health centers in a health care environment dominated by managed care plans. "There are so many questions," said Maureen Hanrahan, director of community and preventive medicine for Kaiser Permanente in Colorado. "The research agenda for school-based health centers is huge. From a provider's perspective, managed care plans want to know how school-based health centers can impact

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Matching Services to Needs

DEFINING THE COMPREHENSIVE SCHOOL-BASED HEALTH CARE MODEL

The first in a series of three articles

One-Stop Shopping for Kids Who Wouldn't Otherwise Go Shopping

When the doors to Ft. Lauderdale, Florida's Stranahan High School health center opened in November 1995, family nurse practitioner Laurel Ela was eager to begin her adolescent practice. But within two months, Ela realized that she was woefully unequipped to handle the broad range of need presented to her by her new patients. "The kids would come in with a complexity of issues that I wasn't prepared for. I'm nosy; I ask a lot of questions. I would talk about their somatic complaints only to discover unidentified depression, sexual abuse, emotional turmoil. And I don't have a mental health background."

Ela immediately asked for help. "I had to voice a real sense of urgency about the need for a mental health position," remembered Ela. The grant from the county hospital district could not be stretched to cover a new staff position; however, a series of discussions with the local education agency and the school's persuasive principal resulted in funding for a full-time mental health clinician. "It took a year, but we've finally got a great complement of physical and mental health services," Ela said.

Ela's challenge is one faced by many school-based health center providers: how do school-based health centers achieve the right mix of multi-disciplinary experience and training to ensure an appropriate fit between need and staffing? Despite certain limited resources, many centers across the country are deciding that it's not a question of choosing between physical or mental health services; comprehensive services are required to address the complex health care problems of many of today's children and adolescents.

An Overwhelming Demand for Mental Health Services

Take Lubec, Maine for example. It's a small coastal town located 120 miles from Bangor, the nearest city. A decade or so ago, there were 27 fish factories operating in Lubec; today there is one. Approximately 42 percent of the 315 students who attend Lubec Consolidated School [grades K-12] come from families whose incomes fall below 125 percent of the federal poverty level, and about 30 percent of the students are uninsured.

There are 275 students enrolled in the Lubec Student Health Center. "We see a lot of acute physical problems," said Marilyn Hughes,RN, C, project director of the center. "But we're also having to focus a lot of energy on mental health problems. We have a mental health counselor who comes to the center once a week and sees 19 kids in one day, and a substance abuse counselor who sees about half that number twice a week. And if we could afford to hire more staff, we could easily fill their time."

"We just can't get enough mental health care on site," said Ray Brady, the center's substance abuse counselor. "The kids have got issues with drugs, alcohol, depression, sexual activity, physical abuse, violence, you name it, it's here."

"Overwhelming" is how Elizabeth "Betsy" Dobbins, MSN, RN, CS, describes the issues students bring to the Hancock County School-Based Health Center in Sneedville, Tennessee, where she serves as a full-time nurse practitioner. Sneedville is another small town whose kids face what are generally considered to be urban issues.

"Some of these kids are dealing with the kinds of worldly issues I never imagined a teenager having to face," said Dobbins. "In many cases, the mental health needs are as great or greater than the physical needs."

To address these issues, the Hancock County School-Based Health Center was opened in 1995 through a partnership between the East Tennessee State University College of Nursing and several county agencies, including the public schools. Like the Lubec school-based health center, the Hancock County center currently is supported by a "Healthy Schools, Healthy Communities" grant from the federal government.

"Before we opened the center, we did a behavioral risk survey at the high school," said Paulette Reed, BSN, RN, the center's health educator. "The survey helped us identify specific concerns for our students. It turned out that we needed to focus on four issues: tobacco use; sexual activity; general wellness, including physical activity and nutrition; and injuries, both intentional and unintentional." To do this, the clinic is staffed by nurse practitioner Dobbins; health educator Reed, a full-time counselor; and a full-time technical clerk.

Early Intervention is Key

Gail Rines, MEd, is the center's full-time counselor, or what the center likes to call its student facilitator. "I worked at a community mental health center before I came to work at the school-based health center," she said. "It was only when teens were involved with the court or the Department of Human Services that they were referred to the community mental health center for counseling. So it was a dream come true when I came to work at the school-based health center. Mental health services need to be in the school because this is where the kids are. Here, I can intervene in a problem before it escalates. Before, I could only treat a problem that had already grown to the point that the court had to force the child into treatment."

When asked what kind of feedback they are hearing from the kids they care for, every member of the center's staff referred to a girl who clearly made an impression on them when she told a local news reporter that she had been on

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a path to self-destruction and would not be alive today if not for the school-based health center. "Some of these kids just feel so stuck; they really just want someone to talk to. And that's exactly why we're here," said Rines when she recounted the girl's story.

When funding for the school-based health center program in Multnomah County, Oregon was increased, program director Denise Chuckovich put the money straight into mental health services. "Originally, we had only had a half-time mental health provider in our centers," said Chuckovich. "So when we got more money, we increased mental health to full-time because we had students on waiting lists to talk to a counselor."

Now, each of the seven school-based health centers located in Multnomah County high schools employs a full-time mental health counselor. "Because we operate multiple school-based health centers, one of the most challenging aspects of our program is maintaining consistency between the staffing of each of the centers, while also allowing the centers to tailor their services to the needs of their individual student populations," said Chuckovich. "So, while we require each center to offer mental health services, one center may focus on counseling for eating disorders while another pays more attention to substance abuse. It's all based on the needs of the kids."

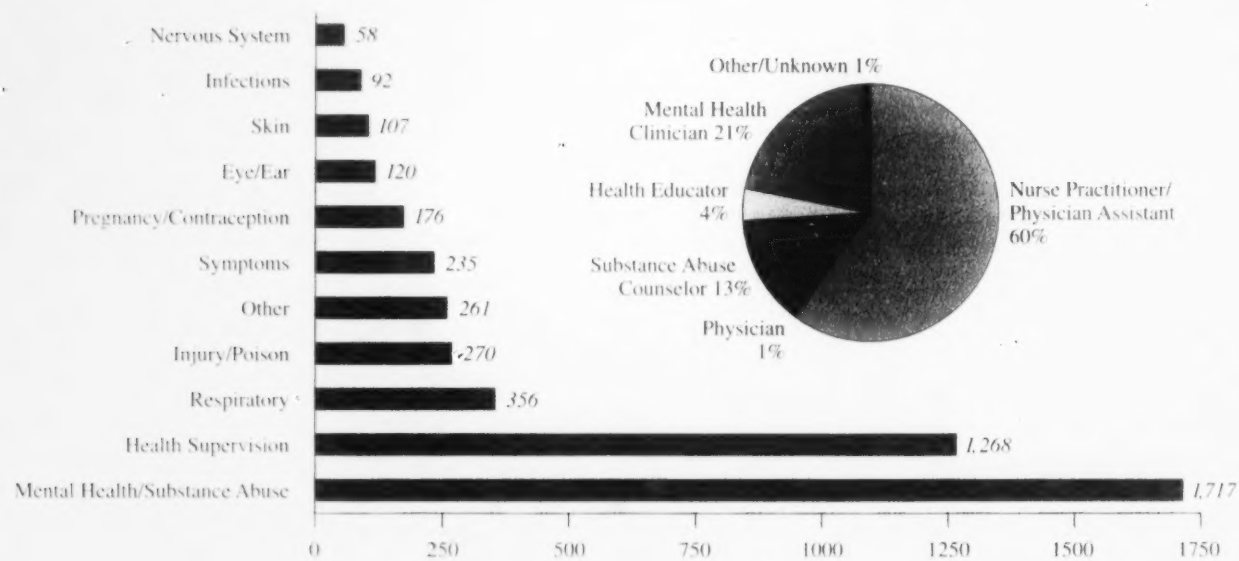
"Comprehensive is the best model. It's one-stop shopping for kids who wouldn't otherwise go shopping. I like to use the term 'holistic.' We take care of the whole child under one roof, which keeps them from having to go to one side of town for physical care and the other side for mental health care..."

Betsy Dobbins

Lubec's Hughes said that the need for mental health services has become much more apparent as the school-based health center has gained the trust of students and parents. "At first, the students didn't come in for mental health services as much because we hadn't gained their trust. And we never thought that we would bill for mental health services because we didn't want any conflicts with confidentiality issues," said Hughes. "But it doesn't seem so impossible now because our counselors are so well-liked and trusted by both students and parents. It's taken a while to reach that point, but we've done it. Clearly, we're doing something right because we didn't have a single pregnancy in the school last year, which is unusual. In previous years, we've had six or eight pregnancies even though we only have about 90 students in the high school grades. I'm confident that by offering comprehensive services we're helping the students take better care of themselves and make better decisions."

The experiences of these and other school-based health centers around the country demonstrate the need for comprehensive health care services for adolescents. "Comprehensive is the best model," said Sneedville's Dobbins. "It's one-stop shopping for kids who wouldn't otherwise go shopping. I like to use the term 'holistic.' We take care of the whole child under one roof, which keeps them from having to go to one side of town for physical care and the other side for mental health care. We keep them all in one place here."

4,660 Visits to Six Colorado SBHCs, July 1996 to December 1996



Data from six school-based health centers participating in Colorado's Making the Grade initiative graphically represent the breadth of activity in comprehensive programs. Mental health and substance abuse services account for one in three visits.

Continued from page 2
important health measures such as immunization rates, initiation of tobacco use, or teen pregnancy outcomes. They also need to understand more clearly how school-based health centers work. Providers still get the centers mixed up with the old idea of a school nurse doling out aspirin.

"And from a business point of view, managed care plans want to know if school-based health centers can function as a value-added service that enrollees might want to purchase," she said. "Would access to a school-based health center be something that would make consumers more likely to enroll in your health plan? And what about the impact on employers? Could school-based health centers reduce the amount of time missed from work by parents tending to sick children? Obviously, these questions aren't part of the public research agenda, but they're very important."

The research agenda for school-based health centers is indeed large, but the researchers interviewed for this article seem to agree on its focus: the clear need is to measure outcomes. "We've definitely learned what we don't need as far as research goes," said researcher Jonathan Klein, MD, MPH, assistant professor of pediatrics at the University of Rochester School of Medicine. "We don't need one or two school-based health centers trying to assess outcomes. We need large national studies that carry enough statistical power to give us the outcomes answers we're looking for, to show us that the centers are having an impact."

For more information about research and evaluation on school-based health centers, please visit Making the Grade's website at: http://www.gwu.edu/~mtg

National Study of Adolescent Health will Provide Useful Data to SBHCs

The first national study to probe the social and environmental influences on adolescent health will report this spring on data collected between 1994 and 1996. The study, called the National Longitudinal Study of Adolescent Health or "Add Health," surveyed some 21,000 adolescents, grades 7 through 12, from 148 public, private, and religious schools across the country. Add Health was designed by researchers at the University of North Carolina at Chapel Hill and funded with a grant from the National Institute of Child Health and Human Development at the National Institutes of Health, with contributions from 17 other federal agencies.

"This is more than a report card of adolescent health," said J. Richard Udry, Ph.D., principal investigator of the study, Kenan Professor of Maternal and Child Health and Sociology, and a Fellow of the Carolina Population Center at the University of North Carolina at Chapel Hill. "Our analyses using these data will examine important underlying factors that determine the health of adolescents."

The central hypothesis of Add Health is that social context is an important influence on the health-related behaviors of young people. In order to test this hypothesis, the study focuses on forces that influence adolescents' behavior: families, friendships, romantic relationships, peer groups, schools, neighborhoods, and communities.

"Adolescents have little opportunity to choose the communities in which they live, the people with whom they live, or the schools they attend," said Udry. "Such contexts, rather, provide the ranges of opportunities within which their choices must be made. Some communities, provide adolescents with many possibilities for interesting, healthful activities; in other communities, the possibilities for self-destructive behavior predominate. Families differ in size, composition, resources, history, and cohesiveness."

This spring, the Add Health research team, having collected and organized the data, will concentrate on analyzing these data; concurrently, public use and contractual data sets will be made available to researchers across the country for additional analyses. Many issues that relate to school-based health centers could be examined with these data.

"The Add Health study is very exciting," said researcher Jonathan Klein, MD, MPH. "Although its precise utility for school-based health centers is not yet known, at the very least it will give us a better sense of what the unmet health care needs are for teens. It will give us a national estimate of how many kids needed care and couldn't get it. If enough kids at schools with school-based health centers were surveyed, Add Health will be able to tell us if those kids had fewer unmet needs."

According to Udry, Add Health asked school administrators if certain specific health services were provided on the school premises, provided by the school district at another school, referred to other providers, or neither provided nor referred.

The study also asked students questions about health service use, diet, exercise and weight control, illness, use of seat belts and other safety measures, sleep habits, violence, sexual behavior, pregnancy and contraception, sexually transmitted diseases, suicidal intentions/thoughts, substance use and abuse, and runaway behavior. Data have also been collected on such attributes as height, weight, pubertal development, mental health status, and chronic and disabling conditions.

In the first release of "public use" data, Add Health codebooks and data set contents will be made available on the World Wide Web after May 1. The Web address is http://www.cpc.unc.edu/addhealth. A second release of data will follow in November. Public use data sets in ASCII format will be distributed on CD-ROM that can be used by several statistical packages. For more information about ordering Add Health public use data, contact: Sociometrics Corporation, 170 State Street, Suite 260, Los Altos, CA, 94022-2812; e-mail: socio@socio.com; phone: 415-949-3282; and fax: 415-949-3299.

Study Examines Teens' Use of Services at SBHCs and HMOs

Adolescents enrolled in managed care may receive more mental health services if they also have access to a school-based health center, according to a new study sponsored by Kaiser Permanente in Colorado. The study found that more than one-third of students with access to a SBHC were seen for mental health and substance abuse services, compared to only three percent of students without access to a SBHC. Conducted with a total of 342 students from three Denver-area high schools who were enrolled in Kaiser Permanente, the study compared the health services utilization rates of 240 students who visited a school-based health center at least once between 1990-1993, and 116 students who did not have access to a school-based health center.

"We did this study because we wanted to see what effect a school-based health center could have on kids who already have access to health care services," said principal investigator David W. Kaplan, MD, MPH, professor of pediatrics at the University of Colorado School of Medicine and head of adolescent medicine at The Children's Hospital in Denver. "Kaiser represented a wonderful opportunity because they had already eliminated insurance barriers, they have facilities that are close to the schools, and they have a group of pediatricians that are very interested in serving adolescents' needs."

Other findings from the study, which has been submitted to a peer-reviewed journal for possible publication, include the following:

- There was little difference between the two groups in the number of medical visits, indicating that access to a SBHC did not increase the number of medical visits among Kaiser-enrolled students.
- A greater percentage of students with access to a SBHC had a comprehensive health supervision visit than did students without access to a SBHC.
- There were fewer after-hours visits (emergent/urgent) for students with access to a SBHC than for those without such access, and a significantly lower percentage of students with access to a SBHC used after-hours services than did those without such access.

"This research project did two things for us," said Maureen Hanrahan, director of community and preventive medicine for Kaiser Permanente in Colorado. "First, it gave us valuable information regarding utilization. We learned that the kids will probably get more preventive care through school-based health centers than they would through our traditional plan. Second, the project allowed us to build a trusting relationship with the schools. The relationship that was established formed the basis for our 'School Connections' partnership" (see box on HMO-SBHC Partnership).

HMO-SBHC Partnership will Care for Uninsured Children

Low-income parents in Colorado have a new opportunity to assure health care for their children. Under a new Kaiser Permanente initiative, for $3 per month per child, parents may enroll their children in the "School Connections" program. A total of 1,300 uninsured, low-income children will be eligible to participate. The program will be made available at 20 Denver-area schools that have school-based health centers. Enrolled children will receive free health care at the centers, and will be entitled to full inpatient and outpatient health care services at Kaiser facilities for a $5 co-payment. The school-based health centers provide physical examinations, treatment of minor illnesses, and immunizations. Certain centers also offer mental health and chemical dependency treatment.

School Connections is a two-year pilot program, and is estimated to cost $1 million annually. Planning for the program has been undertaken by a public-private partnership among the Colorado Departments of Public Health and Environment, Health Care Policy and Financing, the school-based health centers, and Kaiser Permanente. For more information, contact Karen Shields at Kaiser Permanente, 303-344-7425.

Making the Grade

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SUMMER 1997

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Building from the Bottom Up: Community Planning for School-Based Health Centers

Prompted by its early success in two high schools, an urban community sought to create school-based health centers in five elementary schools. The second time around, however, the health center organizers neglected to assess school support and overestimated student need. Several years after they opened, four of the five elementary school health centers closed.

According to state school-based health center experts, this sad outcome could have been predicted. Poor planning produces poor outcomes. Good planning not only reduces the risk of undesirable outcomes but also increases the likelihood that community goals will be met—that centers will be located in needy communities and will be embraced enthusiastically by the families they serve.

State governments that are supporting the development of school-based health centers are urging communities to invest time and energy in a thoughtful planning process. One way states have emphasized the importance of planning is to provide small grants to support the process. "We need to encourage a community's planning efforts because that's when all the local stakeholders come together to assess children's needs and agree on how they should respond to those needs," said Donna Behrens, director of Maryland Making the Grade in the Governor's Office for Children, Youth, and Families, which annually administers about $150,000 in school-based health center planning grants.

"We began inviting communities to seek support for school-based health centers in 1994," said Bruce Guernsey, director of the Colorado School-Based Health Center Initiative. "We started out with such a limited amount of money, $25,000 total for eight one-year planning grants, that we weren't sure any communities would apply. But they did; we received 13 applications that year. And every year since, we've received more applications than we can fund."

Getting Started—Fielding a Team

How do communities go about determining whether or not a school-based health center is right for them? According to those who have done it, there are several important components to the planning process. The first step is always the development of a planning team with broad representation from the community, which will then carry out the actual tasks of the planning process. Those tasks often include: conducting a needs assessment, identifying implementation issues, and building broad community support.

"The first thing I advise people to do is identify the main players in their community—the leaders in education, health, business—who should collaborate in the planning process," said Guernsey. "These people are the foundation of your planning team. The

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Building support for school-based health centers through public awareness and education may be the most important task of any planning team.

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- Public Relations Advice for SBHCs

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team may start out small, with only a few people agreeing to participate. But that's okay because the first task of any planning team is to ask itself who else needs to be at the table? Whose support is crucial to our success?"

Rural Talbot County, Maryland deliberately sought out individuals who opposed school-based health centers to serve on the planning team. "We recruited a group that included one parent we knew was opposed to the idea who we selected for exactly that reason," said John Ryan, MD, the county health officer. "We wanted representation from all perspectives participating from the beginning. You don't want opposition popping up after you've made your decisions."

Once the planning team is in place, the challenge is to create a shared vision among team members who represent diverse viewpoints and differing priorities. For this reason, a newly created planning team may turn to a professional group facilitator.

"We encouraged our planning grant communities to work with experts in group mediation and coalition building," said Marilyn Asay, Making the Grade project director in the North Carolina Department of Environment, Health and Natural Resources, which awarded one-year planning grants of $8,000 to 12 communities last summer. "Without this guidance, the planning teams don't spend the necessary time on collaboration, defining agency roles and responsibilities, clarifying long-term organizational and financial issues. The result is not enough community investment in the center at the time of implementation."

Asheville, North Carolina used part of its planning money to hire a facilitator, an initial task requiring about six weeks. According to Nancy Gatewood of the Buncombe County Health Department, the time invested in recruitment was well worth it because the facilitator helped the team focus. "Our facilitator helped us articulate our goals, identify specific tasks, create a work schedule, form subcommittees, and reach consensus. She also helped us in our relations with the community by leading a public forum, which we used to seek input into the project."

Identifying Need

Planning teams take different approaches to conducting a needs assessment. In some communities, the entire planning process has been precipitated by a needs assessment that revealed the inadequacy of local health services for children. In other communities, the planning team is formed as a result of the interests of specific individuals or recent events that have created alarm. Then, a needs assessment is undertaken to secure more information.

Working with her colleagues in the Department of Health, Sara Simpson, director of the Vermont Making the Grade initiative within the Agency of Human Services, has helped a number of local communities assess their need and readiness for school-based health centers. "The terrific thing about an assessment process," according to Simpson, "is that it enables communities to sort out whether they want or need the centers. And, as a result of the process, they collect data that help them figure out what direction to go in if they decide they don't want a school-based health center."

The Vermont strategy relies on gathering community input through focus groups and surveys. Faculty, school board members, health professionals and other interested community members participate in focus group discussions. Parents and students are invited to respond to specific surveys soliciting their views. Community resource surveys guide identification of services already available in the community. In addition, the Vermont Agency of Human Services makes available a community profile that draws upon data already collected by the state describing indicators of well-being among children and their families.

The process is intense, informed, and—in true Vermont-style—up close and personal. "But this is what gets at what people are thinking," said Simpson. "We can't make assumptions that different communities will respond in the same way to the same circumstances. The school-based centers will not succeed unless a particular school or a particular community identifies the school-based health center as the response they want for their children."

Implementation Issues

If initial planning activities confirm support for a center, there are a multitude of issues that require the planning group's attention: which community agency—or coalition of agencies—will serve as the sponsor? Which types of health care professionals should be included in the staffing to address the needs indicated in the assessment? How will the community provide financial match to the state grant? How will the program be sustained in the future?

Finding a site for the school-based health center, too, is an important task for the planners. It is a task handled differently in every community. In communities where there are few schools, the process can be relatively easy. In larger communities, it can be difficult to choose among many interested and deserving schools. In Wayne County, North Carolina, schools recently competed for the opportunity to host a school-based health center, which necessitated a vote on the part of the planning team. But in Pueblo, Colorado, the principal of one of the schools identified as having a particularly needy student population opposed the idea of a health center. That school was struck from the list of potential sites.

Some of the schools with the most obvious need don't always have space for a comprehensive facility. The planning period is an ideal time to explore creative alternatives to the ever-

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Needs Assessment Tools

School Health Resource Services, a technical assistance division of the University of Colorado Health Sciences Center, has developed a needs assessment starter kit. The resource packet includes sample instruments, local program examples, and step-by-step worksheets for creating, conducting, and compiling results of a health needs assessment. For information on how to order the kit, contact Marilyn Harmacek, project coordinator, School Health Resource Services, (303) 315-5990.

Also, for more information, see: "Comprehensive School-Based Health Centers: Implementing the Model," by Guernsey and Pastore in *Adolescent Medicine: State of the Art Reviews*, June 1996, pp. 181-196. Reprints can be requested from the Making the Grade National Program Office.

Matching Services to Needs

DEFINING THE COMPREHENSIVE SCHOOL-BASED HEALTH CARE MODEL

This is the second article in a series of three. In the last issue of ACCESS, the comprehensive model was discussed in terms of needs identified at the clinic level. In this issue, ACCESS looks at how state governments have supported the development of a comprehensive model.

States Choose a Comprehensive Model

State governments are substantially invested in school-based health centers. They provide some degree of financial support to one of every two school-based health centers in the U.S. Last year, 34 states allocated $41.9 million in state general funds and federal block grant dollars to fund the centers. As states have directed dollars towards the centers they have established requirements that the school-based health centers have had to meet. Increasingly, these requirements have included the provision of both physical and mental health care on site at the school-based health centers.

In days past, the requirement of having both a primary care and mental health professional on-site was derided as an unrealistic "gold standard"—too expensive and unattainable for most communities. Increasingly state officials are concluding that it is too expensive not to respond to the emotional and mental health needs of many students, and that it is unrealistic to believe that a primary care provider alone constitutes sufficient staffing.

"We never thought twice about requiring anything other than comprehensive services because it seems so logical," said Sylvia Sterne, director of adolescent and school health for the Louisiana Office of Public Health. "If you want to have a quality school-based health center program then you better make sure that the kids get the services they need from trained staff who know what they're doing."

The Louisiana grant program, which currently provides $3.85 million annually to 23 centers, was launched in 1992. The legislation that created the program in 1991 requires school-based health centers to be "comprehensive"—a term that is defined in the state's request for proposals (RFP) for the school-based health center grant program.

According to the RFP, the primary goal of a school-based health center is "to meet the physical and emotional health needs of adolescents at their school site." The RFP states that mental health services must be provided in addition to medical services, and requires that the staff include, at a minimum, a part-time master's level social worker or other mental health professional. In addition, arrangements must be made for appropriate referral services and for services that are in operation when the school-based health center is closed.

When Making the Grade surveyed the states several years ago, it found that 22 states had established guidelines for school-based health centers while another nine states were developing such guidelines. With few exceptions, the states defined school-based health centers as vehicles for coordinating and delivering accessible primary physical and mental health services to students. Some of the earliest states to launch school-based health center initiatives, however, did not start out offering comprehensive services. New York was such a state.

"...Some of our centers have provided mental health services from the beginning, but they were the exception rather than the rule. We're now in the process of making them the rule."

Sylvia Pirani

A Difficult Transition

New York has supported school-based health centers since 1980. In the beginning, the state funded a number of centers that provided only primary care. Not until the mid-1990s did the state begin to require centers receiving state funds to provide mental as well as physical health care. The transition has not been easy.

"We've always had requirements regarding the provision of primary care services," said Sylvia Pirani, coordinator of the state's Making the Grade program at the New York State Department of Health. "But we've come to realize that we need something more comprehensive because there's a tremendous need for mental health services among our kids. Some of our centers have provided mental health services since the early 1980s, but they were the exception rather than the rule. We're now in the process of making them the rule."

And it's a big job. The New York State school-based health center program now totals 158 centers, funded, in part, with $10 million in state grants. The state began the conversion to comprehensive services two years ago. In 1996, it issued the final version of "Principals and Guidelines for School-Based Health Centers." The standards were developed with extensive input from school-based health centers around the state. The standards require that mental health services be provided on site and that licensed professional mental health providers be hired.

Pirani noted that the transition to becoming comprehensive has been difficult but necessary for the school-based health centers. Under the new standards, the centers were given the option of applying for state grant funds under two different models—the comprehensive model requires centers to provide mental health services on site, while the intermediate model requires centers to make arrangements for referrals to mental health services. The fact that all but two school-based health centers in the state opted to apply for the comprehensive option, despite

Continued on page 4

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the difficult transition that lay ahead, exemplifies the desire of the centers to attend to mental health concerns.

"All of the sites had problems with recruitment," said Pirani. "The centers have been able to hire the staff they need, but some new staff don't have as much experience as we would like. And there have been problems integrating new mental health staff into the school-based health centers."

A recent site visit by Pirani illustrates this point: a social worker new to the school-based health center expressed frustration because patient confidentiality rules require her not to disclose information about her patients. And yet the school principal wants her to share what she learns with the faculty so that they can work on the problems together. Negotiating these conflicting interests while protecting students' rights is a challenge that many school-based health centers are facing. As Pirani noted, "Both the principal and social worker are trying to help the student. And we're trying to help the centers work through these types of issues."

According to Pirani, the state has sponsored training sessions that focus on building an integrated, cohesive health center staff. The trainings, which have included the key staff from the school-based health centers and the schools, have focused on how to address students' problems as a health care team. The trainings also have focused on teaching the new mental health staff how to join the larger school community, including forging relationships with parents, administrators, and teachers as well as practicing in a school environment.

Service Delivery by School-Based Health Centers in 17 States, 1996-97

	Primary Care and Mental Health	Primary Care Only	Total
Arizona	15	79	94
California	11	24	35
Colorado	22	5	27
Connecticut	49	4	53
Georgia	6	6	12
Louisiana	23	0	23
Maryland	20	12	32
Massachusetts*	21	9	30
Michigan*	7	9	16
New Jersey	8	0	8
New York	142	16	158
North Carolina	19	13	32
Oregon	18	16	34
Rhode Island	3	0	3
Texas*	15	0	15
West Virginia	12	13	25
Total	**397**	**210**	**607**

* Information from school-based health centers funded by state health departments. Centers not affiliated with state office are not included in the count.

Source: Making the Grade survey, April-May 1997

Managed Care and Comprehensive SBHCs

But it's not only the development of state grant programs for school-based health centers that has prompted states to define comprehensive standards. In some states, the introduction of Medicaid managed care also is encouraging the implementation of comprehensive service standards. States that have funded the establishment of school-based health centers are now helping those centers contract with managed care plans, enabling them to continue caring for students enrolled in both commercial and Medicaid managed care plans.

Pirani noted that New York will begin requiring Medicaid managed care plans to contract with school-based health centers next April. She expects that the transition to comprehensive services will help the centers negotiate those contracts because the managed care plans will recognize that the centers are held to state standards similar to those of the health plans.

Connecticut developed comprehensive standards for school-based health centers back in 1985 when state officials began to recognize the need for a "holistic" approach to children's health care. Today, those standards are helping the centers negotiate contracts with managed care plans.

"We have some centers in operation that don't receive funding from the state, so they don't have to meet our comprehensive requirements," said Lynn Noyes, supervisor of the School and Adolescent Health Unit in the Connecticut Department of Public Health. "But we're finding that it's the state-supported centers that managed care plans want to contract with. They see value in the fact that the centers have been held to certain standards and have been required to provide a broad scope of services by qualified staff."

According to Noyes, "Developing the comprehensive model does two things for the state. First, requiring centers to meet certain staffing and scope of service standards offers a measure of consumer protection. Second, it ensures that the state is spending its tax dollars wisely. We're able to make sure that appropriate, high-quality services are being delivered to our kids."

The results of growing state commitment to the comprehensive model—whether in Connecticut, Louisiana, New York or elsewhere—is evident in the above table. Sixty-five percent of the health centers reporting (representing about two-thirds of all school-based health centers in the United States) are comprehensive. Young people attending schools that host these health centers are able to receive care from a multi-disciplinary team for a wide range of emotional and physical health problems. While the newer school-based health center program in Arizona may currently have relatively few comprehensive programs, the older, established programs in Connecticut, Colorado, and Massachusetts have moved decidedly toward the comprehensive model.

Please visit the Making the Grade website (http://www.gwu.edu/~mtg) for a summary of school-based health center guidelines in Colorado, New York, and North Carolina.

Continued from page 2
increasing challenge of the space crunch. Many communities use the period to reconfigure existing school space or construct new facilities.

Community Education

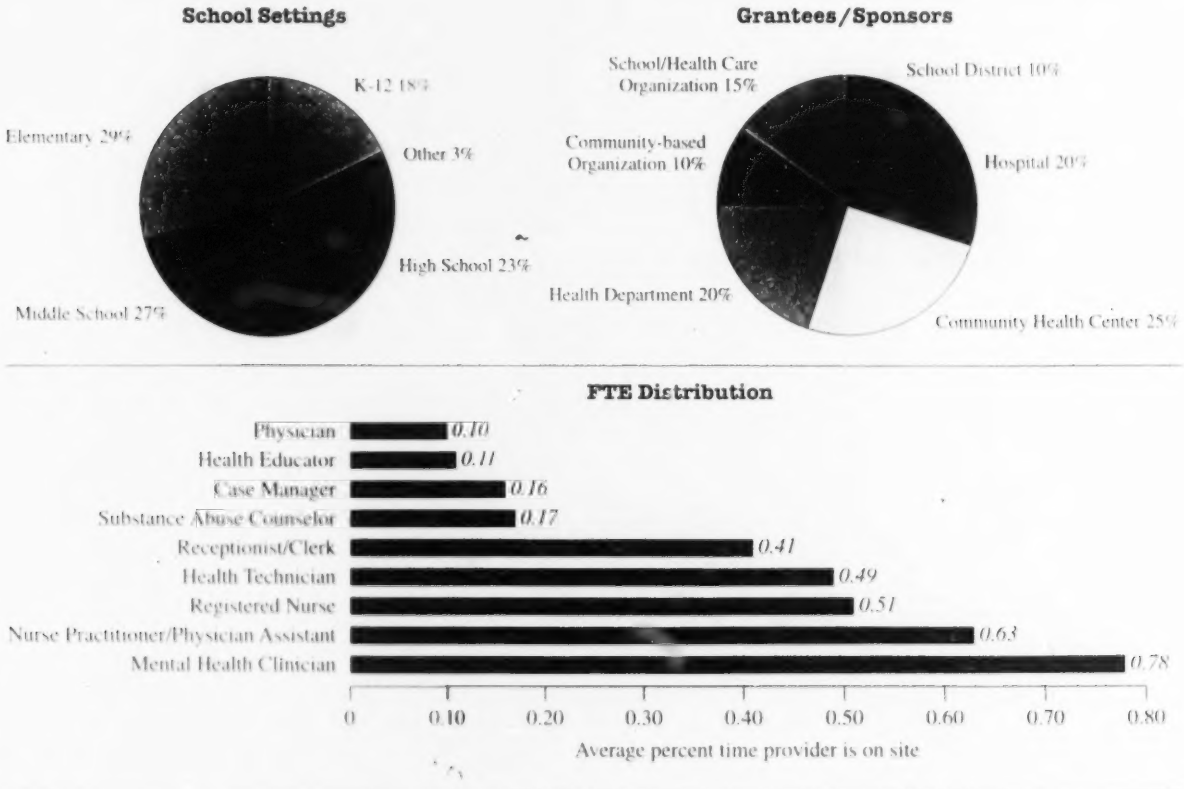
Building community support for school-based health centers through public awareness and education may be the most important task of any planning team. According to Buncombe County's Gatewood, the entire planning process turns on the community's endorsement. "We submitted a proposal to open a second school-based health center a few years ago without going through an elaborate planning process," said Gatewood. "The community never wholly supported it and the plan wasn't funded. Many people complained that they weren't kept informed about what we were doing. So,we did it differently this time." The 29-member planning team issued regular media bulletins, held a public forum, and worked with 100 local leaders to gain support for the center.

Pueblo, Colorado understands first hand the necessity of community outreach. The school-based health centers in that community have been sharply attacked—even while gathering widespread community support. "We maintained constant two-way communication with the community throughout the planning process," said Beverly Samek of local School District 60. "We held public meetings, we sought the support of local legislators, we sent out press releases on every move we made. I think that strategy has really helped us deal with the opposition that developed since our school-based health center opened, but looking back, I think we should've been even more aggressive about outreach than we were. I think we've got the hang of it now."

The planning team in Talbot County, Maryland took its public education mission seriously. Local leaders and community members, particularly those that opposed the idea of a school-based health center, were taken on site visits to successful centers in neighboring Delaware. "As soon as they saw a real school-based health center in action, they recognized the value for our students," said Talbot County's Ryan. "I wouldn't say we changed their minds entirely, but the site visits did convince them to let us give the idea a try."

A thorough planning effort, according to Colorado's Guernsey, can result in a school-based health center that is tailored to the needs of the students it serves while enjoying the benefits of widespread community support. "While there is no formula for the amount of time and effort that needs to go into it, the planning process is a necessity no matter what community you're in," said Guernsey. "Every community is unique—some can take shortcuts through the planning process while others struggle over every decision—but it's the process of local stakeholders determining what's right for their own community that's important."

Making the Grade Local Partner Summary: 20 grantees, 40 school-based health centers



Public Relations as a Catalyst for School-Based Health Care*

*by Andrew Burness***

Last July, Louisiana Governor Mike Foster signed a $2.65 million line item in the state budget that authorized significant new funds for school-based health centers. This would not be so unusual unless one takes into account that, only a few years before, Las Vegas odds makers would have cast the probability of this outcome as something approximating the cancellation of Mardi Gras.

What happened over time in Louisiana was due, in large measure, to superb public relations work, and it's symptomatic of a trend that has seen school-based health centers grow from 350 nationally in 1992 to nearly 900 this year. The Louisiana story [see Summer 1996 *Access*] is perhaps the most dramatic, but it typifies a national trend that has brought school-based health centers from the fringe of children's health care reform to the mainstream in states and communities across the country.

In Minneapolis and St. Paul, two administrators used public relations strategies to attract policy makers to the idea of school-based health centers. Minneapolis' Anne St. Germaine invited then-Mayor Donald Fraser and 100 other important figures in city government to a breakfast at which 30 received awards for their support of public health. St. Germaine rode the coattails of a documentary produced by the office of C. Everett Koop, Surgeon General in the Reagan Administration. The documentary, which was shown on public television, featured the work Minneapolis had done in bringing health services to schools through its school-based health centers.

Mayor Fraser hailed his community's efforts to fight back against organized opposition to the centers. "We have a well-informed community which is willing and able to respond effectively to any questions, concerns, or criticisms," he said. "Instead of a vocal minority, we have a vocal majority."

In neighboring St. Paul, Donna Zimmerman testified before the U.S. Senate Labor and Human Resources Committee. The invitation to testify was made possible through concerted and consistent efforts to obtain visibility for the school-based health care projects in St. Paul. Zimmerman says that improving the social marketing skills of center staff is key to successful promotion of school-based programs. "Clinic staff must be able to articulate the mission of the program in the neighborhood and beyond," she said. "It has been very important to develop leadership qualities in our social workers and nurse practitioners."

In Memphis, Tennessee, Kathy Johnston used dramatic statistics to catch people's attention. "I made sure everyone knew that the babies in our school-based clinic day care program were 100 percent immunized," she said. She knew her efforts had paid off when former first lady Rosslyn Carter and Betty Bumpers, wife of Arkansas Senator Dale Bumpers, brought their immunization campaign to Tennessee and made a stop at one of Memphis' school-based health centers. It didn't hurt that they were joined by Tipper Gore and Mary Sasser, wives of two other U.S. Senators. Not surprisingly, the health center was turned into a wildly successful photo opportunity, as both print and broadcast media converged for what turned out to be a major local story.

From Louisiana to Minnesota to Tennessee, all the evidence points to a movement that is taking off, ready to arrive in the mainstream after years on the fringe of public health and education.

*Excerpted from "Public Relations As a Catalyst for School-Based Health Care," originally published in *Public Relations Quarterly* (Vol. 41, No. 4, Winter 1996-97).

**The author is owner and president of Burness Communications and is a public relations consultant to Making the Grade.

Questions to Consider in Promoting School-Based Health Centers

1. How will you communicate what you're doing (a) in the communities with school-based health centers, and (b) across the state?

2. Which journalists in your state should know about school-based health centers? Who will maintain ongoing relationships with these people?

3. How will you liaison with corporate leadership in your state, and who will coordinate this effort? Which corporate leaders will take the initiative in advocating school-based health centers in the business community?

4. How will you liaison with advocacy groups? Which groups will you approach as partners in this project? Who will have responsibility for implementing an "advocacy strategy?"

5. What is your strategy for encouraging educators to consider school-based health centers in their school districts? What materials will these educators need to be positioned to become active champions of school-based health centers?

6. Does your target population include children or parents from other cultures or countries? If so, does your strategy take translation services and cultural differences into account?

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ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Insurance Expansions and School-Based Health Centers

On October 1, 1997, $4 billion in federal grants becomes available to states to expand health insurance coverage for children. The program, the largest federal initiative to be launched in many years, requires states to use most of these funds to expand Medicaid, create new children's health insurance programs, or expand established ones. In addition, states may spend up to 10 percent of the federal grant for outreach, direct health services, other health service initiatives for children, and administrative costs. The initiative holds important implications for school-based health centers, which provide care to large numbers of uninsured children.

Federal grants, in general, must support health insurance for children who are ineligible for Medicaid and live in families whose income is at or below 200 percent of the federal poverty level ($32,100 a year for a family of four in 1997). Certain exceptions are made for states that provided Medicaid to children with family income above 150 percent of the federal poverty level.

At a minimum, a state's child health insurance benefit package must provide benefits equal to those offered by the state employee health plan, or certain specified commercial health plans, or the largest HMO in the state. The child health plan may provide a different combination of benefits but the total value must equal those in one of the benchmark plans. While cost-sharing is permitted under the state insurance programs, the law exempts well-baby care, well-child care, and immunizations from patient co-payments.

Exact funding levels have not been determined but estimates from the General Accounting Office in August confirm the substantial dollars involved. The largest Making the Grade state, New York, is projected to receive $275 million; the smallest, Vermont, $4 million. States must provide matching dollars totaling 70 percent of their current Medicaid match. States also are obligated to maintain Medicaid eligibility for children as it was in June 1997 and must continue to enroll eligible children in Medicaid.

Inside this Issue

- Case Studies in Funding Comprehensive SBHCs
- Dental Care in SBHCs

Early Support from States

Even before the federal initiative was passed, state legislators around the country made decreasing the number of

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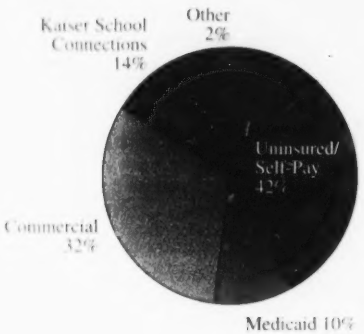
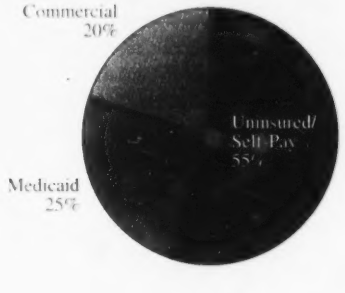
INSURANCE STATUS OF SCHOOL-BASED HEALTH CENTER USERS, 1996-97

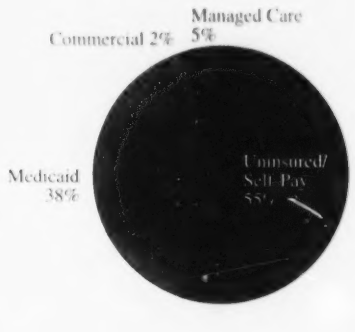
Denver Children's Hospital
Denver, Colorado
(one SBHC)



North Shore University Hospital
Far Rockaway, New York
(two SBHCs)



Montefiore Ambulatory Care Network
Bronx, New York
(ten SBHCs)



Continued from page 1
uninsured children a top priority. During the 1997 legislative season, 35 states introduced bills related to children's health insurance. Legislative approaches included expanding Medicaid eligibility and creating or expanding state child health insurance programs. Nineteen governors set forth their own children's health care proposals. While the final verdict on these proposals is not certain, passage of Medicaid expansions in Arkansas, Maine, Ohio, Oklahoma, Tennessee, and Virginia as well as state insurance program expansions in Colorado, Florida, Pennsylvania, and Texas suggest that it has been a good year for expanding child health coverage at the state as well as the federal level.

Whatever the tally by year's end, more low-income uninsured children will be eligible for health care coverage whether through Medicaid expansions, state-subsidized coverage, or private initiatives. But what will be the impact on children's access to health care services? And what are the likely effects on school-based health centers? And will these federal and state efforts substantially reduce the large number of uninsured children who use the centers?

Who are the Uninsured?

The precise number of uninsured children is debatable. A U.S. Census Bureau report indicated that there were 9.8 million children under age 18 without health insurance in 1995, while the Center for Studying Health System Change estimates 8.6 million. There is enormous fluidity within that number. Thirty percent of all children younger than age 18 lacked health insurance for at least one month during a 28-month period between 1992 and 1995, but some good news was that only four percent were uninsured for the entire period. While uninsurance rates do not differ greatly by age group or by degree of poverty, they do differ significantly by race/ethnicity. Uninsurance rates are reported as 26.8 percent for Hispanic children, 15.3 percent for African American children, and 13.4 percent for non-Hispanic white children.

Filling the Gap: The Role of Private Partners

In addition to publicly supported programs, private programs have helped fill the insurance gaps for low-income children. Blue Cross/Blue Shield's Caring Program for Children has provided health insurance subsidies for children ineligible for Medicaid. Blue Cross/Blue Shield estimates 55,000 children are covered by its 24 participating plans. Over the past 12 years, nearly 250,000 children have benefited from the program. In April, at the President's Summit for America's Future in Philadelphia, the 25 Caring Programs pledged to offer subsidized health insurance to an additional 12,000 children by the year 2000.

In December 1996, Kaiser Permanente in Colorado kicked off its low-income children's insurance program, School Connections. In collaboration with 20 Colorado school-based health centers, Kaiser provides a comprehensive benefits package for a $3 monthly fee for up to 1,300 students who attend schools with school-based health centers. In addition to primary care provided by the school-based health centers, enrolled students are eligible for full inpatient and outpatient health care services at Kaiser Permanente for a $5 co-pay.

Three school-based health center programs report uninsurance rates among registered patients as ranging between 42.5 and 55 percent. The challenge of sustaining services when nearly half the students have no insurance is obvious.

Uninsurance and SBHCs

As the chart on page 1 indicates, school-based health centers have a large stake in the success of efforts to increase children's access to health insurance. Three school-based health center programs report uninsurance rates among registered patients as ranging between 42.5 and 55 percent. The challenge of sustaining services when nearly half the students have no insurance is obvious.

In addition to reducing the number of uninsured children, school-based health centers have at least three other key issues to track as the child health insurance initiative unfolds. First is the degree to which the potential 10 percent set-aside will be used to strengthen the child health care delivery system, including school-based health centers. Second is the development of effective enrollment strategies. It is estimated that one-quarter of children from families below 150 percent of the federal poverty level who are eligible for Medicaid have not been enrolled. Without special efforts, the new state initiatives will likely experience similar difficulties. Given their high rates of uninsured patients, school-based health centers may be particularly well placed to enroll students in both Medicaid and state programs. A third key issue will be the design of the benefits package for the state child insurance programs. As described below, the composition of the benefits package is a critical matter for assuring access to preventive and early intervention services.

While the Medicaid benefit package provides a comprehensive set of preventive and curative services as well as auxiliary services to assure access to care, the states' benefit packages are likely to be less generous. The desire to cover as many children as possible combined with a concern for the state budget and a need to minimize out-of-pocket costs for low-wage working families would suggest that the state child health insurance programs will be making some hard choices about how many children will be covered for what services. Some child advocates speculate that coverage of behavioral health services may be scaled back and that EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Program benefits could be omitted. Thus, while school-based health centers may see a decline in uninsurance rates for their patient population, there may be a poor match between the benefits package and the service mix of the school-based health centers.

During the next several months, state officials, insurers, child advocates, and providers will be shaping the content of the child health insurance package and making decisions about how monies will be spent to improve the service delivery system for children. School-based health centers, their sponsoring institutions, and state offices for school-based health centers will want to be part of these discussions.

Matching Services to Needs

DEFINING THE COMPREHENSIVE SCHOOL-BASED HEALTH CARE MODEL

This is the final article in a series of three. In the spring issue of ACCESS, the comprehensive model was discussed in terms of needs identified at the clinic level. In the summer issue, ACCESS looked at how state governments have supported the development of a comprehensive SBHC model. In this issue, ACCESS reviews how three SBHC programs have maintained their funding for comprehensive services.

Case Studies in Funding Comprehensive SBHCs: The Evolution of Three Programs

In 1987, the Robert Wood Johnson Foundation (RWJ) created the School-Based Adolescent Health Care Program, which awarded grants to support the development of 24 comprehensive school-based health centers in 18 communities around the country. By the program's end in 1993, the comprehensive school-based health centers were to pursue a variety of strategies to replace their RWJ start-up funding with secure sources of long-term funding. Three programs—Northside High in Memphis, Tennessee; Far Rockaway High in Far Rockaway, New York; and Harding High in St. Paul, Minnesota—were asked to prognosticate about the future of school-based health center financing prior to the project's conclusion in 1993. Those projections are reflected in the accompanying table. Funding was anticipated to come from patient revenues associated with care delivered to insured students. Growing awareness of patients' insurance status was leading to greater sophistication of billing, particularly to Medicaid which was the dominant insurer among the center patients. Appropriations from state and local government for care to uninsured children and the provision of non-reimbursable services were also considered crucial to the centers' continued existence.

Four years later, Making the Grade returned to the three programs to learn of their success and challenges. Were they accurate in their predictions? Have they been able to sustain their comprehensive approach to school-based health care? Were they forced to cut services along the way? Today, each of the centers is still in operation, with additional centers having been opened. All found alternative funding sources for their comprehensive programs with relatively minor effects to staffing and services. But certainly, the introduction of Medicaid managed care in the last four years has had the most significant impact on all three programs and their approaches to long-term financing.

Memphis

The Memphis and Shelby County Health Department established school-based health centers in two high schools in the late 1980s. One, the Northside High School Health Clinic, was funded by RWJ's School-Based Adolescent Health Care Program. In 1993, RWJ funds comprised 59 percent of the center's funding base; the rest came from Medicaid patient revenues and from contributions, both monetary and in-kind, from the health department. When RWJ funding expired, program administrators expected to transfer the bulk of the costs to the health department, but hoped also to increase their Medicaid revenues.

Today, the health department covers a greater portion of health center costs than predicted four years ago—80 percent, in fact. Medicaid revenues, despite a volatile few years, remain at approximately 20 percent of the total budget. Each of the two health centers costs approximately $180,000 annually to operate; a figure that has remained stable over the last five years.

In the program's early years, 75 percent of the student population was Medicaid-eligible; that figure increased to 90 percent in 1996. From 1989 until 1994, the centers slowly refined their billing capabilities, and one year actually recouped approximately 35 percent of their budget through Medicaid billing. But that was not to last; in the first six months of TennCare, Tennessee's Medicaid managed care program, each school-based health center saw its Medicaid revenues decline from about $16,000 to $2,500, while TennCare coverage for school-age children was increasing. Today, the centers have subcapitation contracts with five health plans, and TennCare revenues now cover 20 percent of their operations.

Although health department funding has enabled the school-based health centers to continue operating these five years, almost total reliance on one funding source can be risky. "Our two school-based health centers are always in danger of closing for purely budgetary reasons," said Kathy Johnston, RN, MS, school health supervisor for the health department. "If the health department is instructed by the county to cut its budget, it's only logical to cut the two school-based health centers because that cut will affect only a couple thousand kids, who, technically, could seek the same services elsewhere—although we know they won't."

Johnston sees several encouraging signs, however, that indicate things may be changing for school-based health centers in Tennessee. There are now ten school-based health centers in the state. Last year, the state legislature considered but tabled a bill that would encourage managed care plans to contract with school-based health centers. This year, however, the state health commissioner sent a letter to health plans suggesting that they work with school-based health centers.

St. Paul

In 1987, RWJ funded the Harding High School Clinic, which is administered by Health Start, Inc., a community-based maternal, child, and adolescent health care corporation in Ramsey County, Minnesota. During the grant period, Health Start also administered four other school-based health centers in addition to Harding. Today, it administers nine centers, all in St. Paul high schools.

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During the life of the RWJ grant, Health Start's total operating budget, approximately $150,000 for each center, was covered by a diversity of funds including the Maternal and Child Health (MCH) block grant (62 percent); private foundation grants, including the RWJ grant (20 percent); Medicaid and private insurance reimbursements (12 percent), and other state and local contributions (6 percent). In the early 1990s, facing a cap on the MCH block grant support, program administrators turned to Medicaid and private insurance reimbursements—a logical strategy considering that three in four students served by the centers were insured. Aggressive billing led to $100,000 annually in reimbursements from third-party payers for services delivered at the school-based health centers.

In 1993, however, when RWJ funding was ending, Ramsey County introduced mandatory Medicaid managed care. Today, Medicaid and private insurance reimbursements remain at 12 percent of the total budget, due largely to the fact that Health Start had to increase its billing activity to recoup the losses that came from the reduced Medicaid reimbursement rates. "There were precipitous revenue decreases after Medicaid managed care was introduced," said Carol White, executive director of Health Start. "From 1992 to 1993, Health Start's total revenues dropped 23 percent. That meant cuts in all of our programs. We had to cut some health education and nutrition programs in the school-based health centers."

In 1997, Health Start's school-based health centers are still heavily reliant on the MCH block grant, although it now comprises a smaller proportion of the total budget. Additional federal funds have been added in the form of a five-year "Healthy Schools, Healthy Communities" grant, which concludes in two years. To maintain its funding stability in the future, Health Start is joining a newly created integrated service network, called Neighborhood Health Care Network, which, hopefully, will help to increase reimbursements from Medicaid and private insurance. In addition, the organization is expanding its network of private donors.

Far Rockaway

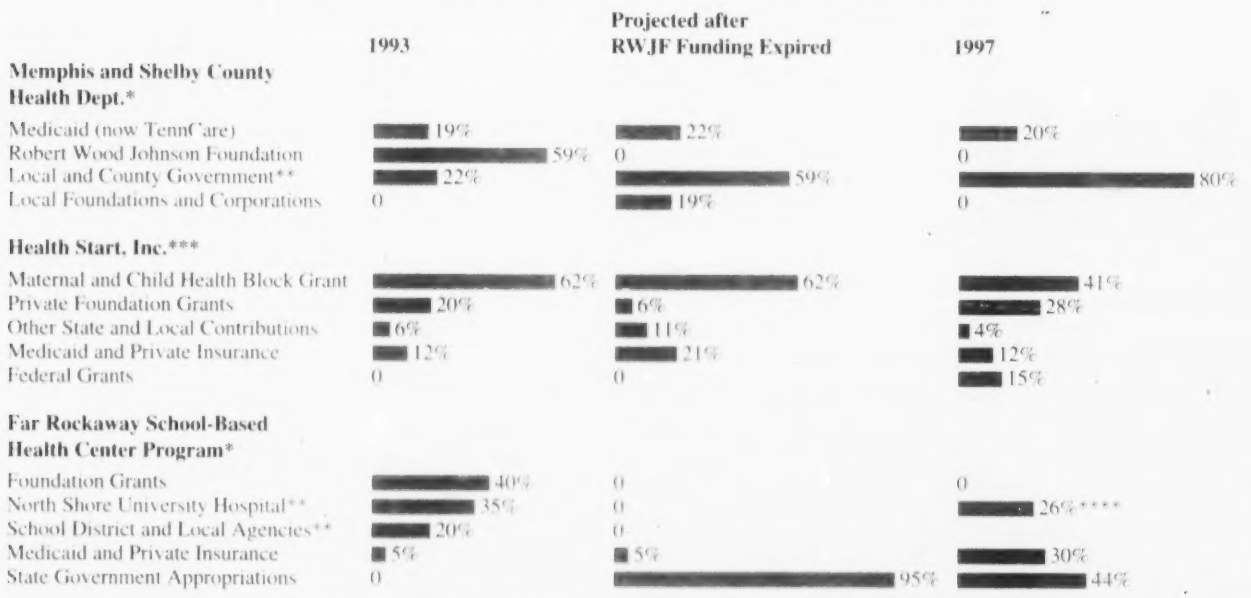
In 1987, the Division of Adolescent Medicine of North Shore University Hospital created the Far Rockaway High School Health Center with a grant from RWJ. That grant comprised 40 percent of the health center's budget, while the remaining costs were covered by in-kind and dollar support from the hospital, school district, and other local agencies. In the early years, there was little emphasis on patient billing; by the time the grant ended in 1993, patient care revenues, primarily Medicaid reimbursement, comprised five percent of the budget (Medicaid-insured students represented 14 percent of the patient population). No support came from the state government. Today, that has changed.

In 1992, the high school health center was combined with a newer intermediate school health center to form the Far Rockaway School-Based Health Center Program, which is funded largely by a grant from the New York State Department of Health. Of the budget, 44 percent is covered by the state health department grant, 30 percent is covered by Medicaid reimbursements, and 26 percent is covered by in-kind and dollar contributions from the hospital, school district, and other local agencies.

The state grant, which was just renewed for five years in 1996, is a relatively stable source of support for the centers. Medicaid is not. In April 1998, New York will introduce a mandatory Medicaid managed care program, which, if the experiences of

Continued on page 6, column 2

Changes in Funding Sources for Three SBHC Programs, 1993-1997



* RWJF funded one of two school-based health centers. 1997 figures include both centers.

** Includes in-kind and dollar contributions.

*** Since 1993, program has expanded from five to nine school-based health centers. RWJF funded only one of the five centers.

**** Combined in-kind and dollar support from hospital, school district, and other local agencies.

Dental Care in Schools: SBHCs Take Comprehensiveness a Step Further

For many first- and second-grade students at Denver's Valdez Elementary School, dental care and education begin at the school-based health center. There, they learn the importance of daily brushing. In fact, they even brush their teeth at school. They also receive screening services and sealant application. When students need restorative work, the school-based health center provides a referral through a volunteer organization called "Kids in Need of Dentistry."

Estelle Meskin, health educator for the Denver School-Based Health Centers, views the program as an investment. "I'm really excited about the potential of a project like this," she says. "We're saving the taxpayers a lot of money by providing these services early on, and we're teaching the kids lifelong skills."

There is a tremendous need for dental services among school-age children, especially those from poor families. In Maryland, for example, a recent oral health assessment of public school children found that students who were eligible for medical assistance had more cavities and received fewer dental services than students whose dental care was purchased through private insurance or out of pocket. "It was clear that children who came from lower socio-economic circumstances had a higher rate of decay and were more likely to go untreated," notes study investigator Mark L. Wagner, DMD, professor of pediatric dentistry at the University of Maryland at Baltimore. He calls poverty a "major cause" of dental decay, which, he asserts, may have a significant impact on students' school performance.

Despite the need, dental services are often difficult for school-based health centers to provide. Reasons may include cost, competing priorities, space constraints and a lack of dental professionals willing to accept low Medicaid reimbursement rates. Yet several school-based health centers have managed to make dental care programs work. These programs, three of which are profiled below, vary in terms of their resources, scope of services, barriers that they've had to overcome, and their strategies for the future. But they are all driven by a firm belief in the importance of dental health for children.

Services on a Shoestring in Denver

In Denver, Meskin launched the dental service at Valdez after an informal needs assessment identified dental hygiene as an issue that was not being addressed among students there, many of whom are recent immigrants and speak only Spanish. Meskin, a former dental hygienist, set to work developing a dental health education and prevention program that could be plugged in at different grade levels.

With a shoestring budget of a few thousand dollars, Meskin pulled together much of what she needed: hygienists' services, toothbrushes, sealant materials, and prizes to encourage good dental habits in the school children. In addition, by collaborating with the health department and the School of Dentistry at the University of Colorado, Meskin developed a valuable network for receiving donated materials and attracting volunteers. The state health department supplied a dental chair, a compressor, and additional sealant material, and dental hygiene students from the university help provide health education and screening services.

"The thing that's so exciting about this program is how resourceful it is," says Barbara Ford, administrator of the Denver School-Based Health Centers. She notes that Meskin herself is a part-time employee. "She's demonstrated how to go into a school and provide these services on a low budget."

A month-long dental health education and screening program was initiated in the spring of 1996 for all Valdez first-graders, followed in the fall by sealant application for those same students as second-graders. That cycle is being repeated this year among the new crop of first- and second-graders.

A 10-year Commitment in Bridgeport

In Connecticut, the state health department has a 20-year tradition of providing dental care. In 1988, the school-based health center at Bridgeport's Bassick High School was the first in the state, and probably among the first in the country, to offer dental services. Kristine Hazzard, supervisor for the Bridgeport Health Department's School-Based Health Center Division, explains that the program got its start with a $57,000 state grant after dentistry students from the University of Connecticut conducted an oral health assessment at the high school and found a "tremendous need" for dental services.

Later it was decided to expand the program to the elementary level, so that some of the problems identified among high school students could be prevented. "We made a decision that every time we opened a new school-based health center, we would push for funding for dental services," Hazzard

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A volunteer dental hygiene student from the University of Colorado educates Valdez students about dental care.

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says. Today, seven of the city's 10 school-based health centers have dental operatories that provide yearly exams, X-rays, cleaning, extractions, fillings and sealant applications, and referrals for specialized services.

Hazzard says she's been blessed with generous funding—about $177,000 for this year—but she still budgets prudently. Dentists are paid $42 per hour, hygienists are paid $22 per hour, and chair site assistants receive $12 to $13 per hour. Each operatory has a dentist for at least one full day a week; two centers where dental service needs are especially high have a dentist two days a week. Under state mandate, the city health department provides hygienists at the elementary level, so Hazzard only has to supply a hygienist for the high school center.

Focus on Funding, Expansion in Kalamazoo

An innovative program in Kalamazoo, Michigan, uses a dental employment firm to provide 20 hours a week of screening, educational, cleaning, prophylactic and some restorative services at the Edison School-Based Health Center. "They tailor their dental personnel to the needs of your program," explains Kai Jackson, program manager for Edison School-Based Health Center/Family Health Center Inc. That flexible approach has enabled the program to double its encounter numbers, she adds.

Jackson notes that Edison is a full-service school-based health center that provides medical, mental and dental health services. The dental program's startup budget was about $43,000, which included a one-time equipment expense of $20,000; next year's budget will be reduced slightly, Jackson says. Most of the money came from a grant from the U.S. Department of Health and Human Services, supplemented with donations from Michigan dentists.

Staffing includes a dentist from the employment firm who provides 16 hours of service a week. One day is set aside for exams and the other for restorative work. A parent volunteer who is a trained dental assistant works at the operatory for 12 hours a week, assisting the dentist free of charge. In addition, a licensed dental hygienist provides 4 to 10 hours of service a week, depending on need, and the center's full-time outreach worker informs and educates parents, students, and teachers about all of the center's services, including the dental program.

Looking ahead, Jackson hopes to expand the dental program by focusing on patient revenues. The best avenue for that, she believes, is to offer adult dental services in the evenings and on Saturdays. Because the dental suite at Edison has its own entrance, those patients could come in for services without going through the school.

"We're located right in the neighborhood," Jackson adds. "We also know that the county clinic can't serve everyone and that there are only three dentists in the city who accept Medicaid, so it behooves us to get into the adult dental business."

Making the Grade

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Developing a Dental Care Program

Providing dental services is no easy task—but it is possible. Here are some tips from several SBHC administrators who have launched and maintained successful dental care programs.

- Invite local dentists to the table when developing your program. If possible, develop a relationship with dentists who have worked in public dentistry, and recruit them for your core advisory group.
- Don't start out too big. Estelle Meskin in Denver began her program by focusing on health education and prevention; sealants came during the second year.
- Nurture relationships within your school—that includes teachers and administrators. It's important to work as closely as possible around classroom schedules so that students miss as little class time as possible. Try to dovetail your work with the school's academic goals. At Valdez, literacy was a priority. Teachers and dental educators worked together to choose books that reinforced lessons on dental care to read to their students.
- Learn what Medicaid and commercial insurers will and won't pay for. See if your state Medicaid department offers seminars on billing.
- Consider using a dental employment agency. Kai Jackson in Kalamazoo says the cost may be comparable with what you would pay a direct contractor. The firm with which she works offered to do a long-term strategic plan for her on how its services would meet her program's needs.
- Network extensively. Meskin says her relationships with the state health department, the University of Colorado, and others proved critical to her program's success.
- Work with dental service suppliers for discounts on your supplies. Also keep in mind that some suppliers and manufacturers may be good sources of materials for your health education programs.

Case Studies in Funding *continued from page 4*

other school-based health center programs are any indication, will significantly reduce Far Rockaway's Medicaid revenues. "When the RWJ funding went away, we worked very hard to increase our Medicaid reimbursements," said Martin Fisher, MD, chief of adolescent medicine at North Shore and medical director of the health center program. "Now, we're concerned that we'll lose some of that revenue when managed care comes in."

Two things, however, will help Far Rockaway. First, the state of New York is requiring its managed care contractors to negotiate with school-based health centers. In addition, Fisher hopes that centers will benefit from the Child Health Plus program, which provides insurance to families who don't qualify for Medicaid and can't afford commercial insurance. "We hope that, if we get fewer dollars per student from Medicaid," said Fisher, "we can make up for the loss by being able to bill for increased numbers of students."

WINTER 1998

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

10TH ANNIVERSARY ISSUE

Exploring the Evolution of School-Based Health Centers

In 1988, the School-Based Adolescent Health Care Program launched a new newsletter, called *Access*, to connect the many different players in what was then a nascent movement to improve child and adolescent health through the development of school-based health centers across the country. The cover story in that first issue was titled, "School-Based Adolescent Health Care Program: New Responses to Changing Problems," and it focused on communicating the need for health services among youth. The article presented school-based health centers as a "new" approach to providing necessary care to an underserved population. It was simple and straightforward and attempted only to communicate the idea that these centers should be given a chance because they seemed to make sense.

When *Access* was launched in 1988, there were less than 100 school-based health centers around the country. Today, there are more than 1,000. Perusing back copies of *Access* gives the reader a glimpse of the evolution of school-based health centers from a limited demonstration effort in 1988 to an increasingly common provider of comprehensive care to children in 1998. Thus, in celebration of the 10th anniversary of this newsletter, here is a look back at school-based care from its earliest days to its emergence as a widely replicated model of services for young people.

A New Idea Takes Root

The first issue of *Access* presented a new school-based health center program funded by the Robert Wood Johnson Foundation, but the idea itself was not new. In fact, the roots of an early center took hold in 1967 in Cambridge, Massachusetts. That year, Dr. Philip Porter, chair of pediatrics at Cambridge Hospital and head of child health for the city health department, hired a nurse practitioner to work in an elementary school rather than in the health department clinic. From that point, the number of school-based health centers increased quietly and sporadically. In 1969, health centers opened in two elementary schools in West Dallas, Texas, with grant funding from the federal Children and Youth Program, which was part of President Johnson's "War on Poverty." In 1970, the West Dallas Youth Center at Pinkston High School opened as an outreach center for the Children and Youth Program at the University of Texas Health Sciences Center. This was the first center to offer comprehensive services delivered by a multidisciplinary team of providers on a high school campus.

"We started our clinics in elementary schools first because that's where the highest rates of morbidity and mortality were occurring among poor children," said Truman Thomas, who, in 1970, was manager of the West Dallas Youth Center, and today is coordinator of the Office of Interagency Collaboration for the Dallas Independent School District. "We expanded our services into the high school almost immediately because we noticed that there was a tremendous need for service in adolescents as well, and the community was extremely supportive of our efforts."

Continued on next page

School-Based Health Centers: A Timeline

1967 Cambridge, Massachusetts health department begins medical services for children in a health center in a K - 8 school.

1970 West Dallas Youth Center at Pinkston High School (Dallas, TX) opens as outreach center for Children & Youth Program at University of Texas Health Sciences Center.

1973 Comprehensive health center opens at Mechanic Arts High School in St. Paul, MN, sponsored by the St. Paul-Ramsey Medical Center Maternal and Infant Care Program.

1972–76 Robert Wood Johnson Foundation (RWJF) funds model school health programs, including school-based health center (SBHC) in Posen-Robbins, Illinois.

1978–84 RWJF funds expansion of primary care in schools through its National School Health Program and the Community Partners Funding Program.

1978 NY legislature approves first state grant program to support SBHCs.

1984 First national conference for SBHCs, sponsored by Advocates for Youth (formerly Center for Population Options), convenes in Houston. Representatives from 34 centers attend.

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Throughout the 1970s, school-based health centers opened in a handful of communities around the country. In 1973, the Maternal-Infant Care Program of the St. Paul-Ramsey Medical Center opened a comprehensive clinic in Mechanic Arts High School in St. Paul, Minnesota, primarily to serve pregnant and parenting teens. As that program evolved, it extended its mission to provide all students with physical and mental health services. And in 1978, the New York State Legislature, encouraged by the success of a few centers in that state, approved the first state grant program to support the development of school-based health centers. By the end of the decade, there were fewer than 50 school-based health centers in the country, but those few that existed were successful at laying a solid foundation for those to come. The first school-based health centers in Dallas and St. Paul continue to function today and have spawned numerous other centers in schools in those communities.

The Development of a Model

The 1980s, particularly the second half of the decade, saw a growing awareness of the potential of school-based health centers to deliver comprehensive physical and mental health care to kids who were going without it. "In 1983, I visited a school-based health center in Mississippi," said Joy Dryfoos, a former professor of public health and director of planning and research at the Alan Guttmacher Institute who is now an independent consultant. "There had been rumors around about a center in St. Paul and one in Dallas, but the reality of those centers hadn't really penetrated outside their communities by the early '80s. So the one in Mississippi was the first school-based center I had ever seen, and I fell madly in love with the idea of delivering services where the kids are instead of requiring them to search for the source of care."

According to Dryfoos, school-based health centers "caught on" in the 1980s because the concept was a culmination of several other developments that had been percolating over a number of years. These included the growing field of adolescent medicine as a sub-specialty of pediatrics; increased awareness of deteriorating health status indicators among adolescents; continued concern for the problems of poor children; and a decision on the part of schools to look outside the educational system for help in addressing the myriad physical, emotional, and social problems that were making it difficult for students to learn. Her interest piqued, in 1984, Dryfoos was one of several people involved in organizing the first national conference of school-based health centers. Sponsored by the Center for Population Options (known today as Advocates for Youth), the conference was held in Houston and was attended by representatives from 34 school-based health centers around the country.

Two years later, in 1986, the Robert Wood Johnson Foundation announced its decision to fund the School-Based Adolescent Health Care Program (SBAHCP). The Foundation had "gotten its feet wet" funding model school-based health centers through previous grant programs, but this was to be the first major grant program focused on replicating the comprehensive model around the nation.

"We knew from previous, albeit limited, experience with the concept that school-based health centers had demonstrated success in getting both boys and girls to come in for care," said Paul Jellinek, a vice president at the Foundation. "Also, we knew that the concept appealed to communities because they were asking us for money to open these centers. And from our standpoint, putting services where the kids are made good, plain sense. So we started the grant program because we wanted to determine if the model was generalizable across the nation."

According to Jellinek, that grant program, which lasted from 1986 to 1992 and resulted in the creation of 24 school-based health centers in 18 communities, determined that the model is replicable. "We discovered that yes, it was possible; the country was ready for the concept – not in all places, mind you, but in many," he said. Today, the Foundation continues its support of school-based health centers through the national Making the Grade grant program.

Expansion Brings Growing Pains

The late 1980s and early 1990s not only saw tremendous growth in the number of school-based health centers across the country, but increased visibility of opposition to the model. While organized opposition varies from non-existent to significant, all communities have learned the importance of testing local opinion for support. Even today, controversy over the centers almost always focuses on two sensitive issues: reproductive health care and parents' rights. Such opposition occurs despite the fact that community input determines the services offered at the school-based health centers as well as the fact that the health centers require written parental consent before students can become patients.

When the Dade County Health Department applied for and was awarded a Robert Wood Johnson Foundation grant in 1986 to establish a school-based health center in Miami's Northwestern High School, then Governor Martinez, supported by a vocal minority of people who opposed the center, declined the grant award on behalf of the government agency. Despite the governor's actions, which went against the wishes of the majority of the school's parents, and despite the bomb scares that threatened the lives of school board members, a school-based health center was finally opened in the high school in 1988, with funding from the Foundation instead going to the Dade County Public Health Trust.

"There was a lot of apprehension in the beginning, but that's reversed now," said Angelia Williams-Welch, a nurse practitioner and supervisor of school-based health centers for North Dade Health Center-Public Health Trust. "Through the whole uproar, people kept saying the center was going to be providing abortions, which wasn't true. The center's advocates just tried to remain calm and kept repeating the

In Memoriam

The staff of Making the Grade is deeply saddened by the recent death of our friend and co-worker, William "Bac" Bacquilod. Bac passed away after a brief illness at George Washington University Hospital on January 17, 1998 – it was his 28th birthday. As senior administrative assistant at Making the Grade, Bac kept our office running. As listserv administrator and Making the Grade web master, he kept us in touch with many of you and brought school-based health centers into the electronic era. As our friend, he kept us laughing. He will be greatly missed by all whose lives he touched.

Making the Grade User Survey

This survey is designed to obtain feedback from users of our communications activities, specifically the ACCESS newsletter, the School-Based Health Center Net (listserv), and the Making the Grade web site. The findings will help us improve our communications and better serve our audience.

This survey is also available on the Making the Grade web site. Please complete one survey only.

Unless noted otherwise, please circle your answers and give only one answer.

1. What is your profession?
   a) Health Educator
   b) Nurse Practitioner/Physician Assistant
   c) Physician
   d) School Administrator
   e) School-Based Health Center Administrator
   f) State Department of Health Official
   g) Other, please list_____

2. What percentage of your professional time is spent working with school-based health centers?
   a) 100%
   b) 90-99%
   c) 80-89%
   d) 50-79%
   e) 25-49%
   f) < 25%

3. How useful is the ACCESS newsletter in identifying, answering, and solving problems found in your school-based health center?

1	2	3	4	5
Not at All		Somewhat		Very

4. Over the last 10 years, the ACCESS newsletter has reported on numerous school-based health care issues. We would like input on which topics have been the most valuable to our readers. Please rate the importance to you of each topic listed, with 1 being not at all important (valuable) and 5 being very important (valuable).

Activities and programs implemented at individual school-based health center sites.

1	2	3	4	5
Not at All		Somewhat		Very

Challenges and problems starting up school-based health centers.

1	2	3	4	5
Not at All		Somewhat		Very

Challenges and problems operating school-based health centers.

1	2	3	4	5
Not at All		Somewhat		Very

The relationship between managed care and school-based health centers.

1	2	3	4	5
Not at All		Somewhat		Very

Political barriers in creating school-based health centers.

1	2	3	4	5
Not at All		Somewhat		Very

Long-term financing of school-based health centers.

1	2	3	4	5
Not at All		Somewhat		Very

Mental health issues.

1	2	3	4	5
Not at All		Somewhat		Very

5. Do you have access to the World Wide Web?
   YES NO

6. Have you ever visited the Making the Grade (MTG) web site (www.gwu.edu/~mtg)?
   YES NO

If NO to #5 or #6, please skip to #13.

7. How did you find out about the MTG web site?
   a) The ACCESS newsletter
   b) Making the Grade National Program Office
   c) Through a colleague/referral
   d) Through the School-Based Health Center Net
   e) From another link on the World Wide Web
   f) Other, please specify_____

8. How often do you visit the MTG web site?
   a) Two or more times per week
   b) Once a week
   c) Two or more times a month
   d) Once a month
   e) Occasionally - every six to eight weeks
   f) Seldom
   g) Never

9. How useful is the MTG web site in obtaining valuable information about school-based health centers?

1	2	3	4	5
Not at All		Somewhat		Very

Continued on other side

10. How useful is the MTG web site in identifying, answering, and solving problems found in your SBHC?

1 2 3 4 5
Not at All Somewhat Very

11. Please rate each of the following reasons for visiting the MTG web site in order of importance to you, with 1 being not all important (valuable) and 5 being very important (valuable).

Publications other than ACCESS newsletter
1 2 3 4 5
Not at All Somewhat Very

Financing Strategies
1 2 3 4 5
Not at All Somewhat Very

Frequently Asked Questions
1 2 3 4 5
Not at All Somewhat Very

State Facts
1 2 3 4 5
Not at All Somewhat Very

HEDIS Standards
1 2 3 4 5
Not at All Somewhat Very

General information on school-based health centers
1 2 3 4 5
Not at All Somewhat Very

The ACCESS Newsletter
1 2 3 4 5
Not at All Somewhat Very

What is occurring with SBHCs across the country
1 2 3 4 5
Not at All Somewhat Very

12. What kinds of information would you like to see on the MTG web site?

Please circle up to two choices.

a) Data collected from school-based health centers
b) Laws applicable to school-based health centers
c) How to access the Children's Health Insurance Program money
d) Other, please specify_____

13. Do you currently subscribe to the School-Based Health Center (SBHC) Net?

YES NO

If NO to #13, skip to the end of the questionnaire. If you would like to subscribe, please contact the MTG office for an application. The service is free and the exchange of information among participants is invaluable.

14. How useful is SBHC Net in solving problems found in your SBHC?

1 2 3 4 5
Not at All Somewhat Very

15. Has access to SBHC Net increased your knowledge and awareness about school-based health centers?

1 2 3 4 5
Not at All Somewhat Very

16. How did you find out about SBHC Net?

a) through a colleague/referral
b) through a health journal
c) Making the Grade National Program Office
d) other, please list_____

17. Do you share SBHC Net materials with any colleagues who do not subscribe?

YES NO

If NO to #17, please skip to # 20.

18. To how many colleagues do you send SBHC Net materials?

a) 0 colleagues
b) 1 to 5 colleagues
c) 6 to 10 colleagues
d) More than 10 colleagues

19. How often do you send SBHC Net materials to your colleagues?

a) once a week or more
b) every two weeks
c) once a month
d) occasionally

20. When you choose to reply to messages sent via the SBHC Net, what percentage of the time do you choose to send your message directly to the questioner vs. the list as a whole?

_____% Broadcast to list _____% Direct to one person

Thank you for completing this survey; your participation is greatly appreciated.

Please fax both sides of this page to:
Making the Grade at 202-466-3496

or mail this page to:
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1350 Connecticut Avenue, NW, #505
Washington, DC 20036

truth: that the center was intended to provide comprehensive health care to kids who have parental consent. Eventually, it all worked out."

Today, the John H. Peavy Adolescent Health Center serves approximately 2,500 of the 3,000 students enrolled in the school. In addition, there are now 10 school-based health centers in Miami; two are sponsored by the Public Health Trust and eight by other health care organizations.

While a few communities experienced headline-grabbing high drama, most others generated limited, if any, controversy. For example, Delaware began its statewide school-based health center program in 1985 when the state's Department of Public Health opened a center in Middletown High School. After that, a few more centers were opened using primarily state funding, and then, in 1992, newly elected Governor Carper pledged to put a school-based health center in every public high school in the state. Today, 23 of the state's 29 high schools have school-based health centers.

"When the first two centers opened, there were some concerns and a few people became hostile and voiced their opposition," said Nancy Bearss, coordinator of the Wellness Center at Sussex Technical High School. "There were a few confrontations in which people weren't always reasonable, but we listened to the concerns and addressed them very methodically, one by one. Once the centers were operational, the concerns died down. And once the Governor was elected, the centers became pretty mainstream."

New Challenges Amid Acceptance

By the early 1990s, the dramatic clashes appeared to be dying down and there was growing acceptance of school-based health centers. This was illustrated by the public demonstrations of support on the part of influential entities, including health professional organizations and the federal government. By 1990, the American Medical Association, the Society for Adolescent Medicine, and the American Nurses Association among other health professions organizations had adopted statements in support of the continued development of school-based health centers. In its 1990 publication, *Healthy People 2000*, the U.S. Public Health Service declared that school-based or school-linked health services were "appropriate" vehicles for addressing the health problems of young people. And in 1991, the federal Office of Technology Assessment, in a publication on policy options designed to improve adolescent health, concluded that school-based health centers are "the most promising recent innovation to address the health and related needs of adolescents."

In addition, in the early 1990s, it became clear that political opposition to the centers was waning when first President Bush's Advisory Commission on Social Security recommended federal funding for school-based health centers and then President Clinton included financial support for school-based health centers in his Health Security Act. In 1993, Congress appropriated $5.75 million to create the Healthy Schools/Healthy Communities program, which has resulted in the creation of 27 school-based health centers in 20 states and the District of Columbia.

Despite the accolades and advocacy, school-based health centers are facing new challenges every day, especially when it comes to securing funding. In the early days of school-based health centers, when they were still an experimental concept, funding generally came through grants from public and private sources. Today, as more and more states commit to the idea, the prevailing interest is increasing the support school-based health centers receive through reimbursement from third-party payers, including Medicaid managed care organizations. Currently, at least 14 states either require or encourage managed care plans to include school-based health centers in their networks. In addition, states are now grappling with a new issue that affects school-based health centers: how to spend new federal money allocated as part of State Child Health Insurance Program (CHIP), which seeks to expand health insurance coverage to millions of uninsured children.

"The health care system has changed a great deal since school-based health centers first began," said Bruce Guernsey, director of the Colorado School-Based Health Center Initiative. "Obviously, managed care is a big challenge to us all, as is the new Child Health Insurance Program. Both of these things represent opportunities for growth, but they also bring greater

Continued on next page

Continued from page 1

1985 **Arkansas, Connecticut, Maryland, Michigan, and Oregon set funding for SBHCs through state grant programs and Medicaid payments.**

1985 **Delaware begins statewide school-based health center program.**

1986 RWJF announces funding for **the School-Based Adolescent Health Care Program.**

1986 **Multnomah County (Portland, OR) Commissioners initiate local funding for SBHCs.**

1988 **First issue of ACCESS published**

1990 US Public Health Service **identifies school-based and school-linked health services as model programs that could help achieve Year 2000 objectives for young people.**

1991 President Bush's Advisory **Commission on Social Security recommends federal funding for school-based health centers.**

1993 **Congress recommends $5.75 million in funding for a federal SBHC initiative: Healthy Schools/Healthy Communities.**

1993 RWJF announces funding for **Making the Grade: State and Local Partnerships to Establish School-Based Health Centers.**

1994 **Clinton Health Security Act proposes funding for SBHCs and school health services.**

1994 Graustein Foundation **dedicates $2 million to open new elementary SBHCs in four Connecticut cities.**

1994 US General Accounting Office **issues report, School-Based Health Centers Can Promote Access to Care.**

1995 Kellogg Foundation establishes **$4 million grant support for SBHCs in Detroit.**

1995 Five hundred and eighty-five **participants attend founding of National Assembly on School-Based Health Care in Washington, DC in June.**

1996 Duke Endowment announces **$3 million in funding for SBHCs in North and South Carolina.**

1996 State-directed funding for **SBHCs reaches $40 million in school year 1995/96. Nine hundred centers identified in Making the Grade biennial survey.**

1997 Kaiser Permanente in Colorado **launches School Connections program to insure uninsured children using SBHCs as primary care providers.**

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danger. There's pressure on centers now to catch the insurance wave. We need to make sure that we become accepted as part of the public health safety net so that we can get reimbursed for caring for our newly insured patients. Otherwise, we'll be left out in the cold."

Many states are committed to making sure that school-based health centers are not left "out in the cold." In New York, for example, the state Department of Public Health requires managed care plans that enroll beneficiaries of Medicaid and Child Health Plus, the state's expanded child health insurance program, to contract with school-based health centers. Negotiating those contracts to assure that high-quality care is provided and properly paid for is proving to be a long and difficult process, but one the state wants to see work out.

"We have 151 school-based health centers in New York and 100 of them are funded with $10 million from the state, so we're clearly committed to the concept."

"We have 151 school-based health centers in New York and 100 of them are funded with $10 million from the state, so we're clearly committed to the concept," said Barbara DeBuono, commissioner of public health for the state of New York. "Our biggest concern now is getting a firm link established between the centers and managed care plans; we want our school-based health centers to be a part of the network that provides a continuum of care to kids. But creating an interface between entities that haven't worked together before is an arduous process."

The same difficult process is being played out in other states as well. For 10 years, Connecticut State Senator Toni Harp has been an advocate for school-based health centers. It's an ongoing process that she believes will continue for years to come. "My most recent efforts were to join with a few other legislators to argue that some funding for school-based health centers come out of our new CHIP money," she said.

New Partners Spur Continued Growth

But even while existing centers are negotiating new relationships with insurers, there has been increasing interest in the idea from other funders, including hospitals and foundations. In 1994, the Graustein Foundation pledged $2 million to open school-based health centers in elementary schools in four Connecticut cities; in 1995, the Kellogg Foundation dedicated $4 million in grant support for school-based health centers in Detroit; and in 1996, the Duke Endowment announced $3 million in funding for school-based health centers in North and South Carolina. The Duke Endowment funding supports the development of school-based health centers through hospitals, which is another growing source of support for the centers.

"There's a growing awareness among hospitals that school-based health centers can help fulfill a hospital's community-focused mission," said Lua Blankenship, president and CEO of The Children's Hospital in Denver, Colorado, which has been a partner in supporting school-based health centers for more than 10 years. "We're absolutely convinced that school-based health centers are cost-effective. It doesn't take a rocket scientist to figure out that providing care to kids in schools is beneficial for everybody — for parents, who don't have to take time away from work to take their child to the doctor; for schools because healthy kids are better able to learn; for hospitals because primary care keeps kids healthy and out of the emergency room; and most of all, for kids, who aren't put in the terrible position of getting really sick and then having to go to the hospital."

Karen Hacker, director of adolescent and school services for the Boston Public Health Commission and president of National Assembly on School-Based Health Care, agrees that school-based health centers make sense to hospitals: "We're definitely seeing a trend toward more hospitals sponsoring centers. Child health insurance is the next big change in the system and school-based health centers are a way for the hospitals to spread their nets wider to capture more insured patients. It makes perfect sense for them."

Today, school-based health centers are found in 45 states and the District of Columbia. However, while the number of school-based health centers is growing almost exponentially, only a fraction of the nation's public school children currently are being served. So, while school-based health centers have entered the mainstream, there are still many opportunities to grow as well as challenges ahead.

Some Things Remain the Same

For all the change and growth that has characterized school-based health centers during the past 10 years, certain fundamentals have remained the same. In 1988 in an issue of *Access* devoted to the role of community partners in sustaining school-based health centers, SBAHCP director Philip Porter commented: "I don't know a successful clinic that doesn't have a parent or community organization behind it." In the same article, Julia Lear, then co-director of the program, concurred: "Community support is the engine that drives school-based health centers."

Ten years later, Lear, who is now director of Making the Grade, argues that community support is more important than ever. "With no obvious or certain means of long-term funding, school-based health centers need to make their case to the community," she said. "The best way to keep the community supportive is to keep the community involved. It's hard work, but it's necessary to assure our continued growth over the next 10 years."

Making the Grade

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SPRING 1998

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

Local Funding for SBHCs: How Did They Do That?

School-based health centers (SBHCs), historically have been supported by a mix of both public and private grants. According to a 1990 survey, the majority of SBHCs are funded in large part by one or more of the following: state health departments, private foundations, and the federal government. In addition, today, there is much emphasis being placed on increasing third-party reimbursements as a means of gaining long-term financial stability for SBHCs.

There are, however, other, often overlooked sources of funding for SBHCs: local sources, both public and private. Local support is important to SBHCs not only because of the need for funding, but because local support demonstrates that the community is committed, on some level, to the concept of school-based health care and to its centers. A 1996 article by Julia Graham Lear et al. in the *Journal of School Health*, titled "Key Issues Affecting School-Based Health Centers and Medicaid," stated that, in 1995, local resources supplied 46% of the total budgets of 11 urban, multi-site school health center programs. A closer look at the charted budgets for those 11 programs shows that local support ranged from a high of 100 percent of the total operating budget in Seattle/King County, Washington, to a low of two percent in St. Paul, Minnesota.

Now, in an effort to shed more light on the phenomenon of local funding for SBHCs, *Access* takes a closer look at four cities that have relied on community resources to support a majority of their budgets. Those communities are: Denver, which gets at least 57% of its program budget from local sources; Multnomah County (Portland), Oregon, which relies on local support for 73% of its budget; Seattle, whose budget is supported almost 100% by a local property tax levy and by local health care provider organizations; and Dallas, which gets 87% of its budget from local sources, including the school district, which directs a percentage of its federal education dollars to SBHCs. The total operating budgets for these four SBHC programs is $10,801,095. Of that total, $8,472,061, or 78%, is locally derived or directed.

The Budgets of Four School-Based Health Center Programs

Community	Dallas	Denver	Multnomah County, Ore.	Seattle
# of SBHCs	10	12	12	8
Total Operating Budget	$3,970,000	$2,000,000	$3,392,095	$1,439,000[3]
City/County	$3,460,000	$1,140,000[1]	$2,467,061	$1,405,000
% of budget	87%	57%	73%	98%
State	$500,000	$160,000	$101,650	
% of budget	13%	8%	3%	
Federal		$200,000	$444,730	$34,000[4]
% of budget		10%	13%	2%
Third Party		$60,000	$272,362	0
% of budget		3%	8%	0
Other	$10,000	$440,000[2]	$106,292	0
% of budget	<1%	22%	3%	0

[1] City/county includes entities with a public responsibility (eg schools, Denver Health Authority, mental health agency)
[2] Other includes RWJF grant as well as funding from local, private, non-profit organizations and foundations.
[3] Total budget managed by the health department, partner organizations contribute an estimated $30,000-$100,000 annually in in-kind support to each of eight SBHCs. Also, three SBHCs have $117,500 in state and federal grant funds and some sites bring in small amounts from third party billing (less than $10,000 annually for all sites)
[4] Federal $ is from HCFA Medicaid Administrative Match

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Denver

The first school-based health center in Denver, Colorado was started in a high school in 1987 with a grant from the Robert Wood Johnson Foundation. Today, there are 12 school-based health centers in the Denver public schools—in seven high schools, two middle schools, and three elementary schools—and they are supported by a mix of funding sources, with local dollars playing an important role.

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"When the Johnson Foundation grant expired [in 1992], we had three school-based health centers to support, so we started looking for alternative resources," said Dr. Paul Melinkovich, medical and program director of Denver School-Based Health Care. "We found much of the support here in Denver; more than half of our resources today come from local sources."

Specifically, Denver School-Based Health Care is administered and partially staffed by the Denver Health and Hospital Authority, which contracts with the city and county to provide health care to medically indigent residents. The contract is funded by general tax dollars. Each year, the Authority allocates approximately $720,000 to the city's 12 school-based health centers. In addition to funding from the Authority, the Denver SBHCs also are supported by cash and in-kind support from the city's mental health agency, the Mental Health Corporation of Denver; the Denver Children's Hospital; Arapahoe House, an adolescent-focused substance abuse treatment program; the Denver Public Schools; and most recently, Centura Health System.

"We were at the table five years ago [when RWJ funding ran out], and everyone was saying 'let's keep this thing going,' but it was a dicey situation trying to work out who was going to pay for what," said Melinkovich. "I think the support of the mayor may have been what put us over the top—he was so supportive of SBHCs, his political will kept them alive. Another thing that helped was that, at the time, the Denver Health and Hospital Authority was part of the city government, and so with our institutional commitment to indigent care, it was natural for us to assume administrative responsibility for the centers. When we converted to a public authority with the same mission, we simply took the SBHCs with us."

The Denver SBHCs also receive funding from non-local sources, including Maternal and Child Health Block Grant funds from the Colorado Department of Public Health and Environment, funds from the Robert Wood Johnson Foundation through its Making the Grade program, and a "Healthy Schools, Healthy Communities" grant from the federal Bureau of Primary Health Care. But these funds are limited in scope and are used to fund specific expenses at certain centers. In addition, 1997 marked the first year that the Denver SBHCs have done any third-party billing. The program is currently in the process of negotiating contracts with Medicaid managed care providers.

Multnomah County

Like Denver, Multnomah County, Oregon also has 12 SBHCs that are supported primarily by local dollars. Of the 12 centers, 10 are located in Portland public schools—six in high schools and four in middle schools. Two other centers—one in a high school and one in an elementary school—are located in two suburban school districts in the county. The health department will open a thirteenth center in a Portland middle school in January 1999. All 12 of the SBHCs are administered by the Multnomah County Health Department, which relies on county general funds to supply 73% of the total operating budget of the SBHCs.

"Even if insurers reimburse 100% of our costs for delivering care, it's still not enough. We'll still need an additional funding source, like the county money, to cover other expenses."

"When we started our school-based health center program in 1986, we automatically looked at local resources; there really wasn't much thought given to any other kind of funding," said Darlene Young, school based health center program manager for the health department. According to Young, the then-director of the health department determined that school-based health centers made sense, so money was found in the budget to open one. "We've expanded our program fairly steadily ever since," she said.

But, Young also said that setting up that first SBHC in Portland wasn't easy, due to opposition from some parents. Over the last few years, opposition has been eased by holding community meetings and responding to parent concerns. Now, new centers opening face little resistance and schools are even requesting to have a SBHC.

Young feels "very confident" that community support for SBHCs will continue. She said that there are, however, some disadvantages to relying upon local tax dollars for a large portion of the budget. The most notable of these is the fact that as political leadership changes, so do political priorities. Another is the threat of tax limitation initiatives, which have been increasing locally. One passed and enacted major funding reductions for SBHCs and other county services. These are two reasons among many that the SBHCs are turning more toward third-party billing to generate income. To date, the program has negotiated a contract and a grant with two major managed care organizations (MCOs), and is seeking similar arrangements with others. But, regardless of how successful the contract negotiations are with MCOs, Young expects to always need additional sources of funding. "Even if insurers reimburse 100% of our costs for delivering care, it's still not enough," said Young. "We'll still need an additional funding source, like the county money, to cover other expenses."

Seattle

Seattle, Washington's experience with SBHCs began in 1988, when the city provided funding to the Seattle/King County Department of Public Health for a three-year pilot program to create a school-based health center in a local high school. Prior to 1988, the community had applied to the Robert Wood Johnson Foundation for funding for its SBHC, but was turned down. "The community was very supportive of the idea, but there was a lot of vocal opposition coming from outsiders," said Anne T. Curtis, manager of school-age health for the health department. So the city, with help from a supportive mayor, found some money for a pilot program.

Then in 1990, a newly elected mayor held a city-wide summit—including parents, students, educators, health care providers, and social service agencies—to determine ways that the city could work with the school district to strengthen public education. The primary result of the education summit was a package of programs that would

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Federal Law Boosts Prospects of Rapid Managed Care Expansions for Low-Income Children

The Balanced Budget Act of 1997 (BBA), signed by President Clinton last August, creates fertile ground for managed care organizations (MCOs) to expand their role in serving poor children—a circumstance that should alert SBHCs to intensify efforts to negotiate contracts with MCOs. The BBA created this climate by approving a large new pot of funds for states to buy health insurance for low-income children—much of which is expected to be provided by MCOs. The new State Child Health Insurance Program (SCHIP) is a five-year, $24-billion federal grant program that states can use to cover poor children either by expanding their Medicaid programs or creating separate state programs. The BBA also removes long-standing barriers that states have encountered when seeking federal approval to enroll Medicaid recipients into mandatory managed care programs. SCHIP and Medicaid are now the two largest federal funding streams available to SBHCs for third-party billing and managed care is expected to have a strong presence in both programs.

Growth of Medicaid Managed Care

Medicaid managed care has now reached all but two states in the nation: Alaska and Wyoming. According to the federal Health Care Financing Administration (HCFA), in 1997, only eight states—Illinois, Louisiana, Maine, Mississippi, New Hampshire, South Carolina, Texas, and Vermont—had less than 25% of their Medicaid beneficiaries enrolled in managed care. In 29 states plus the District of Columbia, managed care enrollment has reached more than 50% of the Medicaid population. In addition, HCFA reported that, in 1997, 48% of all Medicaid beneficiaries across the nation were enrolled in some form of managed care—up from 10% in 1991—and most of them were low-income women and children. This trend is expected to continue. The Congressional Budget Office, in its *Economic and Budget Outlook: FY 1999-2008*, predicted that, between 1997 and 2003, enrollment in capitated managed care plans will increase at rates exceeding 10 percent annually.

Medicaid Managed Care Before BBA

States have always been able to offer managed care plans to Medicaid beneficiaries as an alternative to fee-for-service care. But states that have wanted to require their Medicaid beneficiaries to enroll in managed care plans, in an effort to control costs, have needed a waiver from HCFA to do so. Prior to the BBA, states had two different types of federal waivers from which to choose: the 1915(b) waiver and the 1115 waiver.

The 1915(b) waivers have been used frequently by states interested in changing their Medicaid program to require enrollment in managed care plans. These "freedom of choice" waivers allow states to waive the right of Medicaid beneficiaries to select their own providers and to place those beneficiaries in one of several managed care plans. Prior to passage of the BBA, states with 1915(b) waivers were subject to the 75/25 rule—they could not contract with managed care plans whose Medicaid enrollment exceeded 75% of total plan enrollment. As of June 1997, 39 states had received approval from HCFA for one or more 1915(b) waivers (see table).

Section 1115 waivers are used by states that want to make changes to their Medicaid programs beyond mandating managed care enrollment, or that want to change parts of other federal welfare programs. Prior to the BBA, the 1115 waiver, as it applied to Medicaid, did not require adherance to the 75/25 rule, as did the 1915(b) waiver. As of June 1997, HCFA had approved such waivers in 14 states.

Medicaid Managed Care After BBA

The BBA amended federal Medicaid law and simplified certain parts of what has been for states a cumbersome waiver approval process. A seemingly major improvement to the 1915(b) waiver process is the Act's repeal of the 75/25 rule; recipients can now be required to enroll in Medicaid-only plans, expanding the list of health plans with which states may contract. The BBA also made the renewal and extension process for 1115 waivers easier.

Of somewhat murkier consequence is the BBA's new Section 1932, which gives states authority to enact mandatory Medicaid managed care without going through the waiver process. Theoretically, Section 1932 seems like an administrative gift to states—allowing the shift to Medicaid managed care without the hassle of the waiver process—but at press time, only three states, according to HCFA official Bruce Johnson, formally had submitted to HCFA to use this approach. States have noted some obstacles related to enrollment exemptions and other issues in Section 1932 implementation. Given these problems and the fact that HCFA's rules regarding the provision of Section 1932 are

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State Medicaid Managed Care Programs as of June 1997[1]

State	1915(b)	1115	Voluntary[2]
AL	X	X	
AK			
AZ		X	
AR	X		
CA	X	X	X
CO	X		
CT	X		
DE		X	
DC	X	X	
FL	X		X
GA	X		X
HI		X	
ID	X		
IL			X
IN	X		
IA	X		
KS	X		
KY	X		
LA	X		
ME	X		
MD	X	X	X
MA	X		
MI	X		X
MN	X	X	
MS	X		X
MO	X		
MT	X		X
NE	X		
NV			X
NH			X
NJ	X		
NM	X		
NY	X		X
NC	X		
ND	X		
OH		X	X
OK		X	
OR	X	X	
PA	X		X
RI		X	
SC	X		X
SD	X		
TN		X	
TX	X		
UT	X		
VT		X	
VA	X		X
WA	X		
WV	X		
WI	X		X
WY	X		

[1] These data are from June 1997; there have been changes since then. For example, New York now has an 1115 waiver. For more information on the programs listed here, see the 1997 national summary data posted on HCFA's Web site. HCFA expects to post 1998 data on its Web site sometime this summer.

[2] Voluntary managed care programs are those in which the states allow Medicaid beneficiaries to choose whether or not to enroll, whereas most waiver programs mandate enrollment.

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be funded by a new property tax. In November of that year, the "Families and Education Levy" was placed on the ballot and voted into law. Over seven years, the levy generated $69 million to be used for the programs agreed upon at the summit, including the creation and maintenance of new SBHCs.

Today, the health department administers SBHCs in eight of the city's 10 high schools and has plans to open three more centers in the coming year. In addition, there are long-term plans to open SBHCs in as many as five middle schools and another high school. The first levy, which provided enough money for seven years of SBHC operations, will conclude in June. A second seven-year levy, which was passed last September, will support the expansion of the SBHC program through 2004.

While the levy supports most of the costs of managing and operating the SBHCs, it does not support the entire budget of each SBHC. Those levy funds destined to support SBHCs go to the county health department, which, in turn, contracts with health care provider organizations—including hospitals and community health centers—to organize and run the SBHCs. According to Curtis, the health department uses the levy funds to contribute $145,000 to the budget of each center, while the partner organizations contribute an estimated $30,000-$100,000 of in-kind support to each of the SBHCs for which they are responsible.

"We currently are putting together a work group to look at long-term support for our school-based health centers," said Curtis. "The second levy passed easily this time, and I imagine it will next time as well, but you never know. It's hard to predict what the political climate will be in the future, so we've got to be prepared. Of course, we're thinking about how we can relate to Medicaid managed care. We're also thinking about arrangements with insurers beyond fee-for-service or capitated payments—like soliciting grants from them that won't be tied to billing."

Dallas

While city or county tax dollars are the source of local funding for SBHCs in Denver, Portland, and Seattle, in Dallas, the local money originates from a different source—the federal government. Specifically, the Dallas SBHC program receives about $1.2 million annually in funding through Title XI of the federal Elementary and Secondary Education Act (ESEA), which allows up to five percent of all federal entitlements paid to a local school district—such as funds for migrant and free and reduced lunch programs—to be pooled and spent on administrative expenses as determined by the school district. In this case, the Dallas Independent School District used the money to create the Office of Interagency Collaboration, which administers the city's 10 SBHCs.

"It's a confusing concept," said Truman Thomas, coordinator of the Office of Interagency Collaboration. "You could argue that we're using federal dollars, but they're also local because we determine locally how to spend the money, and we've decided to spend it on school-based health centers."

The $1.2 million that comes through the Title XI program is collected from eight different entitlement programs, each of which had to be negotiated individually. According to Thomas, the directors of those eight entitlement programs have all been very receptive to giving up a portion of their budgets because the SBHCs serve the same kids the entitlement programs are serving. Since the Title XI funding was instituted in 1995, six new SBHCs have been opened.

In addition to the Title XI funding, the SBHCs are supported by other local sources, including the Dallas County Health and Hospital System and the state mental health agency. The Health and Hospital System, with an annual SBHC budget of approximately $1.7 million, provides the centers with clinic staff, medical equipment and supplies, and lab tests. The Dallas County Department of Mental Health/Mental Retardation annually spends approximately $500,000 supplying mental health services to the SBHCs.

According to Thomas, the advantages of this funding structure are that it inextricably ties the SBHCs to the school district, which is very important to the success of the centers. A major disadvantage is that Title XI only covers administrative expenses, which requires the district to rely on other organizations to cover direct service expenses. Plus, since the funding is provided at the federal level, it leaves the school district vulnerable to the ever-changing political climate. Like the other SBHC programs profiled in this article, the Dallas SBHCs are also exploring third-party billing as a future source of support.

Local resources go a long way toward making SBHCs successful in each of these four communities. Perhaps, most important of all is broad-based community acceptance of and support for the concept of school-based health care, which makes significant local investment possible in the first place.

Making the Grade

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Federal Law Boosts Prospects

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still unknown, its impact on Medicaid managed care expansion is unclear.

Implications for SBHCs

The BBA, through both SCHIP and changes to the federal Medicaid law, offers a larger role for MCOs in providing health care to poor children. This climate creates an urgent need for SBHCs to begin contracting with managed care plans. Because Medicaid managed care programs vary state by state, and often within states, the first step for SBHCs is understanding how Medicaid managed care operates in their own state and/or region. For specific information on Medicaid managed care in your state, contact the managed care office of your state Medicaid Agency. For general information on Medicaid managed care and the BBA, visit HCFA's Web site at www.hcfa.gov.

FALL 1998

ACCESS

TO COMPREHENSIVE SCHOOL-BASED HEALTH SERVICES FOR CHILDREN AND YOUTH

SBHCs Enter the Brave New World of Accreditation

After months of prepping, fine-tuning, and dry runs, Beverly Colon Torres remembers the thrill she felt when she and her colleagues earned the gold seal of approval from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). "It was incredible," said Colon Torres, former assistant director of the George Washington High School Student Health Center in New York City. "We actually got a commendation."

Not only had the school-based health center passed the JCAHO's test with flying colors, it had reflected well on its hospital sponsor, Columbia Presbyterian Medical Center. "It was a very good experience, and the staff was extremely pleased," Colon Torres said. "They felt that it was a real team effort."

George Washington was among the first school-based health centers in New York State to undergo a JCAHO site visit. That was in 1996. In fact, only a handful of centers throughout the country have weathered the test of JCAHO accreditation to date (JCAHO does not keep track of how many school-based health centers it surveys). But as school-based health centers multiply and expand their affiliations with hospitals, health systems, and provider networks, they will find themselves increasingly under the accreditation microscope.

Such scrutiny may be direct, if it entails a JCAHO site visit. Or it may be more indirect, if it comes about through a center's contractual relationship with managed care plans that are trying to win or maintain accreditation status with the National Committee for Quality Assurance (NCQA), a managed care accreditation body. In that case, the center may be asked to submit information on service quality and patient satisfaction to contracting managed care plans, although a plan may want to conduct a site visit as well.

Either way, accreditation is a test that some centers may feel unprepared to face. "If you're part of the accreditation process, you're much more in the mainstream of health care delivery," said Linda Juszczak, a nurse practitioner and former director of two school-based centers that are part of North Shore-Long Island Jewish Health System in New York. "The challenge for many school-based health centers is that they've been operating outside of the mainstream."

It's important, she added, for school-based health centers to take accreditation seriously. "If you're not in compliance, especially in key areas, that can affect the entire sponsoring institution's accreditation," Juszczak said. "That's not a desired place to end up."

It's Like Earning a Degree

Several school-based providers who've been through the white-glove inspection

Continued on next page

How to Prepare for Accreditation

1. Obtain a copy of the accrediting organization's standards.
2. Collaborate closely with your affiliate organization. Be assertive in getting the information you need.
3. Check for overlap between the accreditation standards and federal, state, local, or other regulations for which you are already being held accountable. Make sure you are in fact meeting those regulations.
4. Start preparing early.
5. Review your mission. It can not only inspire but also provide guidance on how to show that you are doing your job.
6. Pay particular attention to your quality assurance/improvement program.
7. Conduct "mock" surveys.
8. For school-based health centers that are trying to meet contracting standards for managed care organizations, focus on billing and coding procedures. Make sure you are accurately describing the services you are providing.
9. Try to get some type of computerized support for quality measurement, billing, and coding. For most school-based centers, that means getting linked to the affiliate organization's computer system.
10. Keep in mind why you are doing this: to demonstrate and improve the quality of the services you provide.

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say that, like any other exam, accreditation is not so bad if you prepare for it. Pam Beal, manager of school-based health services for St. Patrick Hospital in Lake Charles, Louisiana, even went so far as to describe a 1997 JCAHO site visit to Washington Marion High School's health center as "fun." Students helped the center shine by organizing a luncheon for the survey team – preparing the meal, acting as hosts, providing musical entertainment, and offering testimonials on how the center had improved their lives. It also helped that staff at the center had done their homework. The result: a glowing report from the survey team, with a commendation. "They were very impressed," said Marilyn Burton, primary care project leader for St. Patrick Hospital.

"It's a lot like going for an educational degree," said Lon Berkeley, JCAHO project director for community health center accreditation. "You've got to go to class, you've got to study, you have homework, you sweat a lot, you have angst about it, and there's a test at the end. But you get a degree – an accreditation decision – at the end of the process."

School-based health centers are among the 40 or so types of organizations that the JCAHO surveys under its ambulatory care program. It has one set of standards that is divided into two general functional categories: patient-focused and organization-focused. All told, there are 346 JCAHO standards for ambulatory care organizations, but whether or not they apply depends on the types of services provided by the organization. For example, school-based health centers are unlikely to administer anesthesia or provide rehabilitation services, so those standards would not be relevant.

JCAHO surveys are scheduled months in advance, leaving plenty of time to prepare. However, few – if any – school-based health centers undergo JCAHO accreditation on their own. Most go through the accreditation process as part of the survey for the hospital or health system with which they are affiliated, and it may be unclear until the last minute whether an actual site visit to a school-based health center is in the cards.

Colon Torres explained that George Washington was part of an ambulatory care network that included five school-based health centers at the time. JCAHO "could have visited any one of the centers," she said, which meant that all five had to be prepared. Not until the survey team arrived at Columbia Presbyterian did staff at George Washington learn that they would receive a visit. St. Patrick in Louisiana actually asked the JCAHO team to visit one of its school-based centers. "We were very proud of the work being done in the centers," Burton said.

How to Prepare for the Site Visit

So, how does a school-based center prepare for the spotlight?

The first step is to get a copy of the standards, which are available from either the JCAHO or the school-based health center's sponsoring hospital, community health center, or health system affiliate. Collaboration between the school-based center and its affiliate organization is the next essential step.

In most cases, the JCAHO standards require school-based health centers to do things they are already doing anyway. The devil, as they say, is in the details. "The hardest part is literally opening every door in your center, going through all your cabinets, and making sure that there are not things in there that aren't supposed to be there."

Beverly Colon Torres

Columbia Presbyterian helped its school-based health centers prepare by developing summaries of the standards, with check lists, so that the centers could study and perform self-audits. St. Patrick, which is part of the Houston-based Sisters of Charity/Incarnate Word Health System, hired a consultant to assist its school-based health centers. In Alamosa, Colorado, Valley Wide Health Services, Inc., a not-for-profit community health center, assumed responsibility for preparing its school-based health centers for JCAHO accreditation, said June Fry, director of school-based services for Valley Wide Health.

Berkeley said that, in general, the most challenging ambulatory care standards are those related to improving organizational performance. These standards, about 35 all together, are designed to ensure that the organization:

- has a well-designed quality improvement program in place;
- is collecting data on important processes or outcomes related to patient care and services;
- is using the information to make comparisons over time and relative to other school-based organizations; and
- is taking appropriate steps toward improvement.

JCAHO Standards Categories for Ambulatory Care Organizations

It is impossible to list the more than 300 JCAHO standards for ambulatory care organizations. JCAHO divides its standards into two categories as noted below. Examples of the areas covered by the two categories also are given.

Patient-Focused Standards

- Patient Rights and Organizational Ethics
- Assessment of Patients
- Care of Patients
- Education of Patients and Family
- Continuum of Care

Organization-Focused Standards

- Management of Human Resources
- Management of Information
- Management of the Environment of Care
- Leadership
- Improving Organizational Performance
- Surveillance, Prevention, and Control of Infection

Medication use can be another problem area, said Berkeley, noting that organizations must have policies in place to assure the safe selection, procurement, storage, and dispensing of all medications. For school-based health centers with limited storage space, these requirements can be vexing. In addition, all significant medication errors or adverse events must be intensely reviewed, Berkeley said.

But despite these challenges, school-based providers say they did not have to dramatically change their procedures or policies in order to earn the JCAHO's nod. After all, accountability is not a new concept for school-based health centers, which already must meet standards imposed by various federal, state, and even local agencies, depending on where they are located and what services they provide. For example, Juszczak pointed out that data collection and reporting have long been a fact of life for school-based health centers. And centers that have on-site laboratories already are required to meet federal laboratory regulations. If they're doing that, then they're also meeting the JCAHO standards.

Sample Practice Questions to Help Prepare for an Accreditation Site Visit

"Are your medications controlled and distributed in compliance with your policies and procedures?"

"What types of brochures, posters, bulletins or other materials can you show me that provide evidence of education to patients?"

"Do you feel there is adequate space in this office to provide appropriate care to patients and does this space allow for patient privacy?"

"How do you communicate patient care between your organization and the hospital?"

"Where are your credential files kept for your practitioners?"

"Explain to me how you store your sterile supplies."

"Where are your medical records stored?"

The Devil is in the Details

In most cases, the JCAHO standards require school-based health centers to d things they are already doing anyway. The devil, as they say, is in the details. "The hardest part is literally opening every door in your center, going through all your cabinets, and making sure that there are not things in there that aren't supposed to be there," said Colon Torres.

To improve documentation of services like health education in the medical record, Colon Torres and her colleagues created a user-friendly checklist for practitioners to note the services they provide during each patient visit. The checklist then becomes part of the medical record. St. Patrick Hospital tried to provide more oversight consultation for its school-based health centers, said Burton. As a result, a hospital pharmacist visits each center regularly to review medication administration.

The most significant change for St. Patrick's school-based health centers had to do with the delivery of primary care and comprehensive services to students who had no other medical home, according to Beal. The centers took steps to ensure that those students receive a general preventive physical exam every year, from pre-kindergarten through 12th grade. "Now we are in a better position to provide a continuum of services," Beal explained. They are also better equipped to measure and track patient outcomes, Burton noted.

Colon Torres said that the JCAHO's standards are not completely inflexible. Take medication storage, for example. The Joint Commission specifies that oral medications must be stored separately from topical creams. "In a school-based health center, where you have limited space, that can be difficult," Colon Torres said. "But that doesn't mean the medications must be stored in separate cabinets. They may be stored on separate shelves—or even different sections of the same shelf."

"[Accreditation:] It's an excellent opportunity to look at what you're doing, look at what others are doing, and to make improvements that benefit the patients you serve."

Marilyn Burton

Preparing for accreditation can be hard work, school-based providers say, but there are several rewards. First, it is an opportunity to review operations thoroughly, find out what works, what could work better, and make improvements. It is also a chance to get the big picture: How well are patients being served? What services would be of benefit that they're not currently receiving? How can the continuum of care be improved? "It's an excellent opportunity to look at what you're doing, look at what others are doing, and to make improvements that benefit the patients you serve," said Burton.

Accreditation can also bring school-based health centers closer to their affiliate organizations. Burton said that St. Patrick gained greater appreciation of the services that school-based health centers provide. "The employees saw firsthand what great work is being done in school-based health centers that are off site," she said. "The process increased team spirit and really integrated the centers into the health care system."

Finally, there is the gratification of passing an important test. "Because we had gone through the preparation, when the day of the survey arrived, we knew what we were talking about and we knew about the quality of the care we were delivering," said Beal. "We'd do it again today."

Making the Grade User Survey: Here's What You Told Us

The Making the Grade National Program Office recently asked *Access* readers and visitors to its World Wide Web site and the School-Based Health Center Net (list serv) to participate in a "User Survey" to gauge the usefulness of these three services. The results of the survey are outlined below. We found the survey results very helpful and will rely on them to guide future decisions regarding the content of the newsletter, Web site, and list serv. Thank you to all who took the time to respond to the survey; we appreciate your input and welcome any additional comments you or others may want to share with us.

Access

An overwhelming majority of survey respondents reported that the *Access* newsletter is somewhat to very useful in identifying, answering, and solving problems found in their school-based health center. Respondents reported that the most useful topics covered in the newsletter are: 1) long-term financing of school-based health care, 2) the relationship between managed care and school-based health centers, and 3) challenges and problems in operating school-based health centers.

World Wide Web Site

Approximately 87 percent of respondents said that they have access to the World Wide Web, and almost 60 percent of respondents said that they have visited the Making the Grade Web site (www.gwu.edu/~mtg). The majority of respondents said that they access the Web site one or two times per month and find it somewhat to very useful in staying informed about school-based health centers. The top three reasons for visiting the Making the Grade Web site are: 1) to find out what is occurring with school-based health centers across the country, 2) general information on school-based health centers, and 3) state facts. The two topics respondents reported they would most like to see on the Web site are data collected from school-based health centers and laws applicable to school-based health centers.

School-Based Health Center Net

Fifty percent of survey respondents subscribe to the School-Based Health Center Net (list serv). More than 75 percent of those who subscribe reported that access to the list serv has increased their knowledge and awareness of school-based health centers, and nearly 70 percent of those who subscribe find the list serv to be very useful in solving problems in their school-based health centers. Approximately 95 percent of subscribers share materials from the list serv with their colleagues.

Again, thanks to all who participated in the survey.

Making the Grade

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